The Epistemic Crisis of Autism Diagnosis:

False-Negative Autism Assessment, Epistemic Injustice, and the Case of the Humboldt University Autism Clinic in Berlin

Independent Research Report
Critical Institutional Case Study in Adult Autism Assessment

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Abstract

This case study of more than 200 pages documents a highly consequential case that calls the reliability of negative autism assessment itself into question and could help trigger fundamental reform. The paper is addressed in particular to researchers and practitioners in autism assessment, clinical psychology and psychiatry, representatives of Critical Autism Studies and participatory research, patient advocacy, disability policy, medical ethics and patients' rights. It documents in unusual depth what ordinarily remains invisible: not only the final outcome of an autism assessment, but the entire path from the near-impossible allocation of an assessment place, through the individual examinations, submitted test scores and biographical documents, to clinical interpretation, feedback and the institutional effects of the final report. The study thus makes it possible to trace, in an almost completely documented case, how a highly complex adult can be translated within a specialist assessment procedure from a possible autistic person into an institutionally "non-autistic" patient. The reconstruction reveals many sources of diagnostic error—some already identified in research—and highlights significant shortcomings regarding the gathering and weighting of diagnostic evidence, patient feedback, ethical safeguards, scientific traceability, and the transparent justification of results—problems that could similarly arise at other diagnostic centers.

Especially within the heated debate over overdiagnosis and underdiagnosis, this case brings into view a much less examined side of the problem: serious shortcomings within autism assessment itself, and the possibility that false-negative decisions may not merely represent individual errors but may be structurally facilitated by resource scarcity, theoretical assumptions and insufficient quality assurance.

What becomes visible is an epistemic crisis in autism diagnosis. Between resource scarcity, time pressure, outdated diagnostic concepts and limited institutional capacities, current assessment procedures may under certain conditions fail to meet their own scientific standards. At the same time, the case reveals institutional mechanisms of self-protection that may obstruct open engagement with this crisis. This sharpens a fundamental question: under conditions of inadequate quality assurance, who can still be reliably recognized as autistic—and who becomes systematically less visible through the very structure of the assessment process?

The subject is the (Spezialambulanz für Soziale Interaktion) Special Outpatient Clinic for Social Interaction at Humboldt University of Berlin. The author gained access to assessment only after years of barriers to access, a documented ratio of 1,667 applicants to approximately 25 places, a lawsuit against the university, the publication of a preceding study on the diagnostic emergency, and direct letters to the university and clinic leadership. The matter later also became the subject of a petition to the European Parliament. The responsible Senator was also involved.

The same institution whose allocation practice had already been criticised publicly, politically and judicially subsequently assessed its own public critic, without any transparent safeguard against the resulting institutional conflict of interest being apparent, and produced a finding with possible medical, rights under social law and biographical consequences. This constellation reveals a connection between diagnosis, institutional self-protection, research interest and epistemic power that has so far received hardly any investigation.

The case is particularly relevant professionally because the 53-year-old adult who was assessed, himself active in autism research, showed a profile for which current diagnostic procedures may be particularly prone to error: diagnosed ADHD, giftedness, high linguistic and cognitive competence, decades of social compensation, clearly elevated autism-related self- and informant-report scores, an almost thirty-year exceptionally close attachment to his body of work and work activity (special interest), which can be related to concepts such as monotropism and hyper-systemizing, as well as severe and long-term restrictions in social and occupational participation. The clinic was presented not only with oral self-reports, but with books, scientific publications, biographical documents, a film, assessments by others, and a scientific statement on the autism hypothesis that had already been developed before the procedure. The study reconstructs how this long-term evidence encountered standardised instruments, clinical observation, differential diagnosis and an externally opaque "overall assessment" within only a few appointments.

The investigation does not decide, in place of an independent specialist assessment, whether the author is unequivocally autistic. Its subject is a different question that precedes this scientifically: Was the procedure suitable and sufficiently open to seriously examine the existing and scientifically developed autism hypothesis and, if appropriate, to refute it? To this end, the study examines which evidence was actually incorporated, which lost significance over the course of the procedure, how contradictory findings were weighted, which alternative explanations were supposed to account for the overall picture, and whether the patient was still able to correct central misunderstandings before they solidified into a completed finding.

The study identifies a series of interconnected problems: the overweighting of brief social observation in comparison with decades of functional history; the possible confusion of learned social performance with the absence of autistic impairment; the limited institutional usability of extensive long-term evidence; the fragmentation of a coherent explanatory model into several individual categories; the reinterpretation of self-knowledge and disagreement; the lack of transparency of the clinical "overall assessment"; and the danger that objections to the outcome themselves become material for clinical interpretation. Among the concepts developed for this purpose are the evidence-bearing patient, the double subjectivity of clinical interpretation, the self-sealing diagnosis, diagnostic identity erasure, and the production of diagnostic populations.

The investigation therefore intervenes directly in current international controversies. It contrasts the still influential social-deficit-oriented and Theory-of-Mind-shaped approach to diagnosis with research approaches concerning Double Empathy, monotropism, masking, compensation and participatory knowledge. At the same time, it shifts the debate, currently strongly focused on self-diagnosis and possible overdiagnosis, towards the insufficiently investigated counter-question: How often does the system produce false-negative results, particularly among older, highly compensating, verbally strong or biographically unusual adults? And can a clinic operating under severely reduced resources seriously identify autism at all, let alone exclude it? A healthcare system can over-identify certain profiles while systematically overlooking others at the same time. Without research on those diagnostically rejected, this second form of error remains largely invisible.

For the Special Outpatient Clinic at Humboldt University, this creates a specific problem in the philosophy of science. An institution whose clinical and scientific orientation is focused primarily on

social interaction itself decides which persons enter clinical and possibly scientific populations as autistic. If it preferentially recognises those profiles whose autism is clearly observable in social interaction, the populations selected in this way can subsequently confirm precisely the theoretical emphasis according to which they were previously formed. The clinic would then not be exclusively an observer of an already existing object of research. It would participate in its diagnostic production. The documented case cannot by itself prove such systematic selection, but it makes its investigation imperative.

The scandal therefore lies not only in the possible misjudgement of an individual. It lies in the unknown scale of the problem. The Humboldt clinic and comparable institutions apparently have no publicly identifiable systematic follow-up of negatively diagnosed borderline cases, no known false-negative rate, and no robust answer to the question of how many are later diagnosed as autistic elsewhere after all. Nevertheless, their exclusion decisions can permanently affect access to treatment, participation, accommodations and recognition under social law. **A methodological limitation of the procedure can thereby become an institutional statement about the person: What does not become sufficiently visible within a few hours and within a particular theoretical framework is treated as non-existent.**

The study further shows that a negative assessment does not necessarily mean the end of autistic self-description. From the institutionally excluded patient, a new epistemic and political speaking position can emerge: that of the diagnostically rejected autistic person. This does not mean arbitrary self-diagnosis, but a person whose autism was not recognised by an institution without the procedure having sufficiently refuted their biographical, functional and scientifically reflected autism hypothesis. The institution can refuse clinical recognition. It cannot, however, simply control the language with which a person describes their own experience, life history and belonging.

This contains a human-rights and emancipatory dimension. Medical classification, recognition under social law, personal identity and political group belonging are connected, but they are not identical. Clinical institutions can decide which diagnoses they issue. It does not necessarily follow from this that they hold a monopoly over who is permitted to speak as an autistic person. Continued autistic self-description after a negative assessment can therefore be understood as a de-monopolisation of clinical interpretive power: biographical self-knowledge, long-term functional history, perceptions by others, participatory research and knowledge from autistic communities stand alongside clinical assessment, without thereby rendering it categorically meaningless.

This position also possesses a solidaristic momentum. It can strengthen people who cannot obtain an assessment place, whose profile is overlooked because of masking, age, comorbidity, gender, social adaptation or an unusual biography, who have received contradictory findings, or who cannot afford an independent second opinion. The message is not that every self-attribution is automatically clinical truth. The message is that institutional non-recognition must not oblige people to deny their own experience when the diagnostic procedure itself does not transparently disclose its limitations and possible fallibility. The diagnostically rejected autistic person is therefore not a conceptual contradiction, but describes a person who has been excluded from a clinical category without the reality to which this category refers necessarily having thereby been disproved.

The study therefore demands neither automatic recognition of every autistic self-identification nor a right to a particular diagnosis. It demands a right to a reviewable and participatory diagnostic process, of the kind that was precisely not apparent in the documented procedure. Further demands and recommendations include the transparent distinction between non-confirmation and reliable exclusion, documented weighting of contradictory evidence, inclusion of long-term biographical data, disclosure of institutional conflicts of interest, a particular duty to justify stigmatising alternative interpretations, a genuine correction and second-review procedure, and safeguarding in feedback situations with existentially significant consequences. In particularly complex cases, the further question arises whether routine clinical assessment is sufficient at all, or whether interdisciplinary, participatory and open-ended, interdisciplinary and participatory case research is required in order to integrate appropriately the current state of autism research, extensive documentation of work and life, and competing explanatory models.

The final question therefore concerns not only Humboldt University, but international autism assessment as a whole:

How many people were classified as "non-autistic" not because autism was absent in them, but because the diagnostic system was unable to recognise, incorporate, or integrate their form of autism into its own theory?

Keywords: adult autism assessment, false-negative autism diagnosis, autism diagnostic bias, epistemic injustice, participatory autism research, Critical Autism Studies, autistic adults, late-diagnosed autism, missed autism diagnosis, masking, camouflaging, monotropism, Double Empathy Problem, Theory of Mind, social interaction, social communication, diagnostic validity, ADOS-2 limitations, autism screening, differential diagnosis, neurodivergence, ADHD and autism, AuDHD, autistic burnout, lived experience, biographical evidence, patient expertise, testimonial injustice, hermeneutical injustice, clinical epistemology, diagnostic uncertainty, diagnostic transparency, self-identification, diagnostic exclusion, diagnostic identity erasure, self-sealing interpretation, psychiatric misclassification, personality disorder misdiagnosis, institutional bias, conflict of interest, safeguarding, patient rights, disability rights, medical ethics, Rosenhan-Experiment, diagnostic ethics, clinical accountability, institutional responsibility, access to diagnosis, autism healthcare inequalities, underdiagnosis, overdiagnosis, false-negative rates, diagnostic populations, population selection bias, autism research methodology, neurodiversity-affirming practice, adult mental health services, Humboldt University Berlin, Spezialambulanz für Soziale Interaktion, Germany, international autism diagnostics

Translation Disclaimer

This English version is a translation of the original German text. In cases of ambiguity or when quoting the work, the German original should be consulted as the authoritative version:

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Research Value and Key Contributions

This study offers researchers rare access to the almost completely documented course of a negative autism assessment in adulthood – from the allocation of the assessment place, through the submitted biographical, psychometric and scientific materials, to the clinical interpretation, feedback and institutional effects of the finding. Its research value does not lie in determining the frequency of false-negative diagnoses on the basis of a single case, or in conclusively deciding the author's autism diagnosis. It lies in making visible and open to scrutiny diagnostic processing steps that usually remain hidden in published studies, diagnostic reports and clinical routines.

The case study shows how extensive long-term evidence can be selected, translated, weighted or excluded within a time-limited procedure. It investigates how brief social observation, standardised instruments, clinical theory, institutional resources and possible conflicts of interest interact within a non-transparent "overall assessment". In this way, it creates a model case for investigating false-negative diagnosis, epistemic injustice, diagnostic uncertainty and the selection mechanisms through which clinical and scientific autism populations are produced.

As independent theoretical and methodological contributions, the study develops the concepts of the **evidence-bearing patient**, the **double subjectivity of clinical interpretation**, the **diagnostic overall assessment as an epistemic black box**, **self-sealing interpretation**, **diagnostic identity erasure**, and the **diagnostically rejected autistic person**. With the **diagnostic evidence matrix**, a right of correction before the finding is finalised, the distinction between non-confirmation and reliable exclusion, and follow-up of negative borderline cases, it simultaneously proposes concrete instruments for research and diagnostic practice.

For researchers, the study is therefore particularly relevant as a **hypothesis-generating, theory-developing and method-critical case**. It opens questions that must be examined in further cases and with independent data: Which autistic profiles are preferentially recognised by existing procedures? Which disappear from clinical and scientific populations? How must negative findings be documented in order to become scientifically examinable? And to what extent does the diagnosed autism population describe autism itself – or the selection capacity of the institutions that produce it?

The political significance of the case extends beyond the specific assessment to the question of what participation actually means. Participatory autism research and diagnosis do not begin only where institutionally recognised autistic people are invited to communicate their experiences within predefined formats. They must prove themselves precisely where a diagnostically unrecognised, but scientifically informed and neurodivergent person contradicts institutional interpretations. In doing so, the author must not be measured against precisely those communicative, organisational or social performances whose limited availability forms part of the unresolved overall picture. Procedural fairness, epistemic respect and protection against pathologisation must

therefore not begin only after successful diagnostic recognition. Otherwise, precisely those people whose form of neurodivergence the existing system is unable to recognise are excluded from participation.

Participation that is open only to those already recognised, while denying the diagnostically rejected their capacity for knowledge, is not participation. It merely reproduces clinical selection within research.

The question is therefore:
Who is permitted to count as an autistic subject of knowledge at all, if the institution itself decides who gains access to this position?

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Methodological Approach: Provoked Empiricism

The present case study is not designed as a mere retrospective complaint by a patient dissatisfied with the outcome. It had been announced in advance, independently of the result. It follows the method of **provoked empiricism** developed by the author. Institutional structures are not merely described from the outside; rather, through concrete applications, follow-up questions, objections, and the consistent demand for justifications, they are brought into situations in which their actual decision-making logics become visible. The diagnostic process therefore does not merely constitute the object of the investigation; the reactions of the institutions involved to documented criticism, submitted evidence, and demands for transparency also form part of the empirical material.

The author's personal involvement is not denied, but methodologically disclosed. It opens up a level of intervention that is not available to purely external observation. By disrupting routinised procedures and confronting a system with its own claims to justification, conflicts, tensions, and deeper layers can

emerge that remain invisible in normal institutional operation. The reactions that arise from this are not mere accompanying phenomena, but independent data of the investigation.

Personal involvement replaces neither evidence nor scientific examination. It does, however, provide access to processes that often remain closed to purely external observation. What is decisive, therefore, is not whether the author is a party to the conflict under investigation, but whether documented events, subjective experience, scientific interpretation, and political intensification are distinguishable from one another in a traceable way. The study thus examines not only which diagnostic outcome the clinic reached, but also what happens when an evidence-bearing patient systematically makes visible the premises, contradictions, and consequences of that outcome.

At the same time, the method has clear limits. Provoked empiricism does not allow a complete reconstruction of internal consultations, individual motives, or undocumented decision-making processes. It can make institutional reactions visible and develop reasoned hypotheses from their structure, but it cannot unambiguously attribute every observed reaction to a specific intention. The author's involvement can also influence perception, selection, and intensification. The present study therefore claims neither neutral external observation nor a conclusive explanation of all events. Its scientific claim lies in the transparent documentation of a conflictual course of events, the verifiable separation of different levels of statement, and the development of questions that must be examined in further cases, through independent research, and on the basis of additional institutional data.

The author does not employ this method for the first time in the present case. For decades, it has formed a recurring component of his qualitative research in confrontations with institutions, companies, and state authorities. This approach is public and extensively documented. Based on the institutional history, the submitted publications, and the publicly accessible body of work, the institutions involved were also aware that the author does not merely process institutional reactions personally, but documents, analyses, and publishes them as empirical material. The clinic therefore did not assess a patient whose scientific working method was unknown or unforeseeable to it.

Ethics and Data Protection Notice

The author, the person examined, and the author of the case study are identical. The author publishes the medical, biographical, and institutional information concerning himself in the knowledge that it will remain permanently publicly accessible. Statements from conversations that were not recorded are identified as memory protocols or as recollections of their approximate meaning. Information concerning other persons is reproduced only insofar as it is necessary for reconstructing institutional actions, diagnostic decisions, or their consequences. The study was conducted independently and without institutional affiliation; no institutional ethics approval was obtained.

1. From Denied Access to the Investigation of Diagnosis

This investigation begins where the preceding study initially ended: with access to autism assessment.

In *1667:25 Violence, Health Harm and the Denial of the Rights of Autistic People in Germany - Proceedings before the Social Court Cottbus and the Higher Social Court Berlin-Brandenburg - On the Practical Impossibility of Enforcing Effective Legal Protection for Neurodivergent People* (Speed 2026), 129 pages documented how access to specialised autism assessment for adults was effectively made dependent on chance. The shortage of diagnostic provision is a globally known problem. The study presented showed, through a concrete case, the real effects on those affected.

In the quarter examined, 1,667 people competed for approximately 25 assessment places. The study showed that this was not merely an unpleasant waiting period, but a structural blockade. Humboldt did not make the fatal figures visible to the public and thus left most people believing they had a chance of obtaining an appointment. Statistically, this was unlikely for many, meaning: it would take years.

As documented in the study, the author had put the Berlin Senate under pressure through several letters, including to the relevant commissioners. The responsible Senator felt compelled to respond personally and reply to the author. This may subsequently have led to changes that had been announced to the author by the responsible Senator, but not to changes that would have helped those affected; instead, they amounted to further administrative defence mechanisms. Apparently only a few weeks later, the clinic wrote on its website:

> *"Important notice: Our autism assessment service is exclusively available to persons residing in **Berlin, Brandenburg or Mecklenburg-Western Pomerania**! Due to the very high demand, we are unfortunately unable to offer assessment to persons from other federal states."*

Whether this paragraph had perhaps already been there earlier could no longer be clarified retrospectively. This therefore rests on the author's memory that he had not previously read these passages on the website.

The Senator had written to the author on 4 December 2025:

> *"I ask for your understanding that the extremely unsatisfactory waiting times for an assessment place in Berlin for people with corresponding needs also arise because, until now, it has been decided not to restrict admission to autism assessment, in accordance with the allocation of responsibility of service providers to place of residence inherent in social law, solely to persons whose residence is in Berlin."*

Access to assessment was therefore being, or was intended to be, restricted even further. This is important because it shows how the problem was shifted within Germany. The burden was thus moved to some extent from Berlin towards other federal states, which faced similar problems and had previously in part shifted their burden towards Berlin.

It had apparently been recognised that the situation was politically sensitive. Presumably, there was no intention to invest more money. Whether this happened as a direct response to the author's criticism, however, remains unclear.

One diagnostician initially indicated to the author that the actual figures might possibly be published. Later, however, the website continued to contain the politically neutral formulation:

"The search for autism assessment in adulthood can be very lengthy and confusing."

The scandal surrounding the diagnostic shortage was thereby quasi-normalised, rhetorically de-dramatised, and the suffering of thousands of people was thus made invisible and less threatening. From the perspective of the present investigation, the problem was not solved in this way, but administratively and rhetorically displaced. In this sense, Humboldt too participated in a political de-dramatisation of the diagnostic shortage.

Without a recognised diagnosis, accommodations, participation benefits, social-law entitlements and suitable support frequently remained inaccessible. At the same time, the absence of clarification and continuing institutional non-responsibility intensified health, social and material crises. The lack of access to diagnosis thereby became part of a self-stabilising loop: no diagnosis, no rights; no rights, no stabilisation; no stabilisation, hardly any real possibility of still enforcing diagnosis and rights.

This study therefore apparently did not remain without consequences. It was not only published, but submitted to the university outpatient clinic, the leadership of Humboldt University, political bodies, commissioners, judicial institutions, the Berlin Senate and international institutions. Even to the Federal Constitutional Court. It had also been sent to numerous researchers. Humboldt University thus knew that its conduct was no longer merely the subject of an individual complaint procedure. It was being scientifically documented and was becoming increasingly public.

After approximately two weeks had passed without either an acknowledgement of receipt or a substantive response from the clinic leadership, the author again contacted the President of Humboldt University and the head of the clinic, Prof. Dr. Isabel Dziobek, directly. In this message, he referred to the study, hazard notifications, ongoing political and legal steps, the international dissemination of the study and the announced continuation of the investigation. The tone was sharp. It nevertheless corresponded to the assessment documented in the study that lack of diagnosis and institutional non-response in relation to a highly vulnerable group do not constitute mere administrative failures, but can contribute to severe and foreseeable health harm, including deaths. The message therefore did not mark the beginning of the escalation. It stood at the end of a long chain of applications, complaints, lawsuits, warnings and absent responses.

Prof. Dziobek, head of the university outpatient clinic, received two emails. The first on 6 March 2026:

> *Dear Prof. Dziobek,*
>
> *following the decision of the Higher Social Court Berlin-Brandenburg (as you know, I had sued Humboldt), the study on violence against autistic people in Germany has now been completed and published. It is also going to Geneva and Brussels. The paper places a serious burden on your clinic. There is a high probability that suicides and indirect deaths must be assumed as a consequence of the lottery system. The scale is reminiscent of the Contergan scandal.*
>
> *As a fellow researcher, I would like to call on you to comment on the study and to exert influence on the Senate. Human lives are at stake here and are being massively endangered.*
>
> *The study has been published in German and English and can be found here:*

Speed, T. (2026). 1667:25 Gewalt, Gesundheitsschädigung und die Verweigerung von Autist:innen-Rechten am Beispiel Deutschland, dem Sozialgericht Cottbus, sowie beim Landessozialgericht Berlin-Brandenburg. Zur Unmöglichkeit der Durchsetzung von Rechtsschutz für Neurodivergente (unter Lebensgefahr). (1 German). Zenodo. https://doi.org/10.5281/zenodo.18875540

Speed, T. (2026). 1667:25 Violence, Health Harm and the Denial of the Rights of Autistic People in Germany - Proceedings before the Social Court Cottbus and the Higher Social Court Berlin-Brandenburg - On the Practical Impossibility of Enforcing Effective Legal Protection for Neurodivergent People (1 English). Zenodo. https://doi.org/10.5281/zenodo.18887765

I ask you to take the matter seriously. The paper will probably sooner or later also reach the press. Humboldt cannot simply ignore this.

Kind regards

Timothy Speed

https://timothy-speed.com/

On 20 March 2026, she and University President von Blumenthal received the following email:

Dear Prof. von Blumenthal, Prof. Dziobek,

You have now had the study for approximately two weeks. So far, I have received neither an acknowledgement of receipt nor a response. Since we are speaking here about hazard notifications and human lives, I urgently ask you for a statement.

The Senate and the responsible commissioners have been informed. A complaint has also been submitted to the UN body responsible for compliance with the CRPD, as well as a petition at EU level. The study is therefore becoming increasingly public. It has already been sent to 100 researchers worldwide. The Prosecutor General has also been informed.

As scientists, you have a duty to ensure that truth is not covered up. If you continue to remain publicly silent, you directly contribute to human lives being endangered. The second study following the first will comprehensively document how you respond to the paper and will thereby also make this accessible to the research community. For the first time, we have the opportunity here to show comprehensively how fatal the consequences for autistic people are.

As researchers, you know that through the existing procedure you contribute to massive health harms. These are foreseeable. If you retreat to the position that you are not responsible, or cannot do anything, that would be cowardly and a failure to provide assistance. It would be unworthy of Humboldt. You must respond massively and publicly. Otherwise, every suicide resulting from this will also be on your account.

You are playing with the suffering and lives of a highly vulnerable group in order to save resources. This is not an administrative question, but a highly political one.

Kind regards

Timothy Speed

Speed, T. (2026). 1667:25 Gewalt, Gesundheitsschädigung und die Verweigerung von Autist:innen-Rechten am Beispiel Deutschland, dem Sozialgericht Cottbus, sowie beim Landessozialgericht Berlin-Brandenburg. Zur Unmöglichkeit der Durchsetzung von Rechtsschutz für Neurodivergente (unter Lebensgefahr). (1 German). Zenodo. https://doi.org/10.5281/zenodo.18875540

Speed, T. (2026). 1667:25 Violence, Health Harm and the Denial of the Rights of Autistic People in Germany - Proceedings before the Social Court Cottbus and the Higher Social Court Berlin-Brandenburg - On the Practical Impossibility of Enforcing Effective Legal Protection for Neurodivergent People (1 English). Zenodo. https://doi.org/10.5281/zenodo.18887765

The court proceedings were formally dismissed by the Higher Social Court and subsequently went to the Federal Constitutional Court, where they were initially accepted for examination and then likewise formally dismissed by the judges of the Federal Constitutional Court. This was because the author could not afford a lawyer. There was therefore no investigation of the facts. The Federal Constitutional Court did not conduct a substantive examination, even though the matter and the possible consequences for thousands of affected people described by the author had been submitted to it. What significance this information had for the decision cannot be inferred from the decision itself.

On 1 April 2026, the author therefore once again registered for the lottery procedure of the specialised outpatient clinic. There was no alternative. In its general email to all affected persons, the clinic stated that it would respond within two weeks if a place on the waiting list could be offered. This deadline passed. Only on 22 April, eight days after expiry of the period specified by the clinic itself, was contact nevertheless made with the aim of admitting the author through the lottery procedure as a participant in an assessment.

Whether this access resulted exclusively from the regular selection procedure or whether the political and institutional pressure that had meanwhile developed played a role cannot be conclusively determined due to the lack of transparency. What can be established, however, is that access occurred outside the previously communicated timeframe and that, at that point, the university and clinic leadership had been informed about the study, the lawsuit, the political complaints and the announced further documentation.

This had the consequence, however, that the question of whether the clinic, for reasons of protecting itself or others, had actually drawn the author "at random" from the pool inevitably remained attached to the public space of the case.

This had direct consequences for the question of what motives the clinic might possibly have been pursuing and how this might affect the later diagnosis.

Correction and Addendum on the Connection Between Access to Diagnosis and the Legal Proceedings

On 22 August 2026, after the first version of this paper had been published, the author received a letter from the Social Court of Cottbus enclosing a submission from Humboldt University dated 27 May 2026. In it, the University's legal department wrote:

> "..., that in the second quarter of 2026, within the lottery procedure, the claimant received an invitation to a screening interview and thus notification of admission to the diagnostic process on 22 April 2026. A screening telephone call with the claimant had already taken place on 23 April 2026, and the diagnostic appointments were scheduled for 1 and 4 June 2026. These appointments were confirmed by the claimant. The defendant therefore asks once again whether the claimant intends to withdraw the action. Should the claimant not withdraw the action, the defendant requests that the Court, pursuant to Section 102(2) SGG, call upon the claimant to pursue the proceedings."

The newly discovered submission substantially changes the assessment of the institutional context in which the diagnostic process began. For the first time, it directly documents that the author's admission to the diagnostic process was linked by Humboldt University's own legal department to the ongoing court proceedings. Before the Social Court, the granting of access to diagnosis was expressly used as a reason to press once again for withdrawal of the action brought against the University. The subsequent diagnostic process was therefore not merely institutionally accompanied in time by a legal conflict; access to that process was itself part of the procedural dispute. The connection was therefore real and not merely a retrospective interpretation by the author.

The matter is therefore politically far more explosive than a mere temporal overlap between litigation and diagnosis would suggest. The proceedings did not concern an ordinary personal dispute, but a structural problem of the shortage of diagnostic provision and the fact that access to the very limited number of diagnostic places was, in practice, almost unattainable under conditions of extreme scarcity. The preceding study had specifically raised the question of whether a healthcare system in which 1,667 people compete for approximately 25 places still adequately fulfils its protective, care-related and participatory functions. The author had escalated this issue politically, scientifically and through the courts. The action therefore had at least the potential to subject not only his individual access, but the legitimacy of the existing allocation system itself, to further judicial and public scrutiny. It was a human rights case.

Against this background, the author's subsequent admission to the diagnostic process acquires additional institutional significance. It has still not been possible to determine whether his selection resulted exclusively from the regular lottery procedure or whether the political, scientific and legal pressure that had developed by then played a role. This question remains open. The new submission does, however, show that the University immediately used the access that had been granted to press for termination of the ongoing legal dispute. The diagnostic place therefore had not only a medical function for the University, but also an identifiable procedural one.

The decisive question is therefore: **Was the diagnostic place merely an individual solution to a healthcare provision problem—or was it also used as a solution to a litigation problem?** The new submission does not prove that the author's admission occurred solely or primarily for procedural-strategic reasons. It does, however, document that the University expressly used the granted access to diagnosis as an argument for bringing the legal dispute directed against it to an end.

From the perspective of this study, this creates the impression that the structural problem of the diagnostic shortage was not addressed first; instead, the concrete case of the claimant, which had by

then become particularly politically and legally sensitive, was to be removed from the procedural dispute as quickly as possible. While hundreds or even thousands of other affected people continued to face the same barriers to access, the access granted to one individual claimant was immediately used before the Court as a reason to request withdrawal of the action. No visible structural reform benefiting the remaining affected people initially followed from this.

This is precisely where the human rights significance lies. A structural conflict can be institutionally defused not by changing the underlying structure, but by providing access to the individual case through which that structure has become legally and publicly visible. The individual claimant then gains access while the system itself remains in place. If this individual access is subsequently used to press for termination of the proceedings directed against that system, there is a risk that a structural problem is translated back into an allegedly resolved individual case.

In the present case, this also intensifies the question of the independence of the subsequent diagnostic process. If the granted access to diagnosis had already served institutionally to defuse an ongoing legal conflict, this may have created an additional pressure toward resolution of the case. Such pressure need not have been consciously transmitted to individual diagnosticians in order to become scientifically relevant. The institutional situation alone would have required a particularly clear separation between the legal department, the University leadership and the medical-scientific diagnostic process.

It is important to know here that Humboldt selected affected individuals for all diagnostic facilities in Berlin. This applied not only to the Humboldt outpatient clinic, but also to Charité and other clinics. The University outpatient clinic could therefore have arranged for the author to be assessed by another clinic. Prof. Dr. Dziobek did not do so. And this was precisely where the first ethically and scientifically concerning problem already arose: the issue of possible bias.

It would also have been more difficult for the University to use the author's access to diagnosis against the human rights proceedings if it had not carried out the diagnostic process itself.

In fact, this marked the beginning of a second investigation.

The first scandal consisted in the almost insurmountable barrier to access. The second began with the question of what happens within assessment once such a place is finally reached, and under what conditions this occurs. Access to a procedure says nothing yet about its quality, its openness towards unusual biographies, its capacity to correct its own misunderstandings, or the practical usefulness of the finding produced at the end.

The University Outpatient Clinic for Psychotherapy and Psychodiagnostics (Spezialambulanz für Soziale Interaktion) at Humboldt University of Berlin, including within it the Special Outpatient Clinic for Social Interaction, together with its director and co-signatory of the later diagnostic report, Prof. Dr. Isabel Dziobek, thus became material for the second study.

But what, then, were the initial conditions?

It must first be stated that the author was clinically recognised as having ADHD, and was therefore neurodivergent, with the sole problem that ADHD explained only part of his life. The author showed

an unusually high density of features that current research associates with autism, monotropism, hyper-systemizing and Veridical Mapping. His style of thinking was deeply monotropic and hyper-systemizing. He therefore exhibited a series of features whose density and cognitive structure resemble patterns that research often attributes to autism. He also had the sensory features, as well as strongly repetitive behaviour. In the interest of scientific integrity, it should be stated here that the author, as a person active in autism research, is certain that he is autistic, because over a period of years he has examined this scientifically, theoretically and professionally to an extent that, in terms of the density of evidence, far exceeds the procedure of a diagnostic assessment. At the age of 53, the author did not arrive at this conviction lightly, but submitted papers and studies, sought professional advice and weighed the evidence. All of this evidence is publicly accessible in his research and can be examined. See also **Appendix 1**.

The problem that emerged in the following investigation was less the absence of evidence for the diagnostic criteria of autism than its exceptionally large volume, which overwhelmed Humboldt from the outset. This then led, in the further course, to these data, or so it at least appeared, practically not being considered at all.

A reductive procedure stood against an expansive quantity of data from real life.

It is scientifically important to make clear here that the author continues to describe himself as autistic and will continue to do so, irrespective of Humboldt's view. For Humboldt did not refute the scientific basis in this procedure. Essential evidence was not addressed with a single word. Not even when asked. In addition, there was the professional opinion of an autism-experienced psychotherapist outside the procedure, who affirmed autism.

The clinic's diagnostic assessment remained recognisably strongly oriented towards an ICD-10-influenced and social-deficit-oriented perspective. Newer approaches concerning monotropism, Double Empathy, masking, compensation and non-linear autistic cognition were, at any rate, not integrated into the report in a traceable manner. From the reconstruction of the report, the impression emerges of a substantial overweighting of observable social deficits compared with long-term biographical evidence, masking and inner experience. For a large university outpatient clinic in 2026, this appears extremely irritating.

The diagnostic starting situation was unusual from the outset. The author did not encounter the clinic only as a patient. He had previously sued the institution, publicly criticised its allocation practice, alarmed the Senator and numerous commissioners, published an extensive study on the diagnostic emergency, and announced that he would also scientifically document the university's further conduct. The clinic was therefore simultaneously service provider, object of criticism and diagnostic authority. The author was simultaneously patient, plaintiff, critic, human-rights activist and researcher of the procedure.

The overlap of roles at least established a substantial appearance of possible institutional bias and should therefore have been explicitly examined, documented and disclosed to the patient before the procedure began. Under these conditions, the neutrality of the procedure could not simply be assumed; it would have had to be actively established and documented. The later assessments cannot meaningfully be examined without taking this history into account.

The author did not expect automatic confirmation of his autism hypothesis. Of course he hoped for it. He did, however, fear concrete diagnostic problems that he raised in advance (see Appendix 1) and that later also appeared.

In principle, he expected that a specialised university institution would seriously examine the exceptionally extensive biography, the available test scores, the publicly accessible body of work and the already written explanation of his way of thinking and working. For the assessment, therefore, not only the author's books and published papers were submitted, but also the *Scientific Statement on the Need for Explanation When Rejecting an Autism Spectrum Hypothesis*, written on 12 February 2026. This statement is included in full with the present paper as **Appendix 1**. Readers can therefore directly examine which information was available to the clinic before its final decision and what was apparently not addressed.

The statement was not a retrospective defence against an unwanted outcome. It existed beforehand. It described the stable attachment to his body of work over decades, the discrepancy between high self-organised productivity and failure in ordinary employment relationships, the possibility of pronounced masking, and the functional and health-related costs of the entire constellation. It therefore already formulated in advance what a serious assessment in this particular case especially needed to attend to.

As already mentioned, the author himself worked in autism research, although predominantly in systems theory. He investigated the relationship to world and world-formation in the context of neurodivergence, cognition, consciousness and society. He was not institutionally embedded in a university, but worked unpaid as an independent researcher; Humboldt nevertheless knew this.

The two published works *Thinking in Formation* (Speed 2026) and *Work under Eigenzeit* (Speed 2026) had also been submitted. The first examined the stable form of knowledge and work production over decades in the context of autism, the second the dependence of capacity for work on self-organised temporal and structural conditions. Both texts had been published with DOI and were therefore independently accessible. The author submitted his book *Denn sie können nicht verstehen – Warum Autismusforschung irrt* [*Because They Cannot Understand – Why Autism Research Is Wrong*], in which, among other things, Prof. Dziobek had also been criticised for, in the author's view, marginalising masking in autistic people in a lecture. Whether this passage in the book had been read remains unclear.

This unusual situation revolved in particular around an important detail that the author expressed to the diagnosticians right at the beginning of the first assessment appointment (memory protocol):

> *"You have to understand one central thing. I have been almost continuously unemployed for 27 years, but for almost 30 years I have worked 40 hours a week on a very specific form of art and research centred on examining a particular pattern relationship in social and scientific structures. – Basically, I can only do this one kind of work. Everything revolves around this work. It gives me energy, and when I do not do it, I lose energy; I can watch my IQ fall, watch myself become clumsy and make mistakes. I cannot work with people. I have to do everything in my own particular way and have therefore been excluded, discriminated against and driven into poverty for decades."*

There was therefore a striking profile whose totality could in any event not be accounted for by ADHD, giftedness or the later alternative interpretations without leaving a considerable explanatory remainder. The author's giftedness did not explain this either. The body of work showed phenomena such as Veridical Mapping and pronounced monotropy. The author's texts frequently do not develop their claims linearly from a thesis towards a final result, but in a circular, repetitive and condensing manner. This form of writing is therefore not merely style, but part of a stable cognitive organisation that recurs in the work, the biography and the form of knowledge production. It does not in itself prove autism, but constitutes another diagnostically relevant long-term trace that can be related to monotropism, non-linear meaning formation and autistic cognition.

In addition, there is the author's particular way of working. His capacity for work is not evenly available, nor can it be accessed independently of time, context and self-organisation. It arises above all within longer phases bound to his own temporal rhythm, in which perception, action, meaning and work production merge into a coherent process. Under such conditions, exceptionally high continuity and productivity can arise over years. If these processes are interrupted, however, by externally imposed timing, frequent changes, externally set goals or contradictory institutional demands, this does not merely result in loss of motivation or reduced performance, but in a marked collapse of energy, coordination and capacity for action. This extreme dependence of performance capacity on self-organised temporal coherence does not in itself prove autism, but represents another diagnostically relevant long-term trace. It can be related to monotropism, context-bound functioning and autistic or neurodivergent *Eigenzeit*, and should therefore have been examined as a structure of the entire course of life and work rather than visible work production being read wholesale as an argument against disability, which apparently then occurred.

The following investigation therefore does not initially ask whether the author is autistic. This question can and should be assessed independently by other researchers on the basis of the accessible documentation, the body of work, the test scores and the diagnostic material. Insofar as this is possible at all. Independently of what the author himself believes.

For scientific classification, however, it must be disclosed what the initial situation was and why an autism hypothesis existed in the first place.

For the author, who published on autism, autism explained everything in his life. After 50 years of not knowing, this produced a profound resolution of decades-long riddles and burdens. If neurodivergence as such had therefore been established, namely ADHD, why should it then not also be autism, if autistic features were massively more strongly represented than those of ADHD? And if research recognises the high probability of comorbidity.

Here, a conflict of aims within diagnosis itself already becomes visible, namely the question of whom it is actually for. Whom is it supposed to benefit? And what happens when the formalisms of diagnosis reach limits at which they become harmful for those affected because they stand closer to a clinical administrative act than to the reality of patients' suffering? When the explanation offered by the professional world ultimately leaves those affected without a satisfactory explanation. Because the label within its boundaries becomes more important than the less clear-cut life itself.

What is investigated here now is not the question of whether autism was present, but how the specialised outpatient clinic produced a diagnostic picture from the available information. Which materials entered this picture? Which disappeared? What significance was given to the patient's statements, and what possibility did he have to identify and correct misunderstandings before they condensed into a completed judgement?

Only on this basis can it be assessed whether the later finding merely represented a professionally differing assessment or whether it revealed a more fundamental problem of adult autism diagnosis.

Methodological Identification of the Levels of Statement

> The present study distinguishes between documented events, memory protocols, subjective experience, scientific interpretation and political intensification. Events supported by written documentation are presented as such. (cited) Statements from conversations are, where no recording exists, identified as memory protocols or approximate recollections. Descriptions of internal effects refer to the author's experience. Statements concerning institutional motives, intentions or functions are not treated as established facts, but identified as hypotheses or interpretations. Politically intensified terms such as scandal, violence, gaslighting or institutional self-protection designate analytical or normative evaluations of the documented constellation and do not constitute a claim of demonstrated individual intent to cause harm.

2. Access to the Procedure

On 22 April 2026, the author therefore received an appointment offer from the Special Outpatient Clinic for Social Interaction at Humboldt University of Berlin.

The process was already statistically striking. In the quarter examined, 1,667 people had competed for approximately 25 places. Even under strongly simplified assumptions, the probability of being selected at least once within four participations was only about 5.9 percent. If access in fact occurred on the fourth participation, this particular sequence corresponded mathematically to a probability of approximately 1.4 percent. These figures can only represent an approximation because essential procedural data were not publicly available: the exact number of applicants newly entering and leaving in each round, changes in capacity between quarters, the number of people referred via Humboldt to other clinics, and the precise weighting of previous participations. These uncertainties were already at the core of the preceding criticism. Outwardly, the lottery procedure appeared to be a transparent procedure of equality, while its concrete functioning remained largely opaque.

The statistical improbability does not prove that the author was deliberately selected. It gains significance only within the temporal and institutional context. Access did not occur during a neutral phase, but after the author had sued the university outpatient clinic, publicly criticised its allocation practice, published an extensive study on the diagnostic shortage, and personally called upon the university and clinic leadership to respond.

Thus, an event with a low probability of occurrence coincided with a period of substantial institutional irritation. Without claiming direct causality, the question arose under what conditions a system that had remained stably unresponsive for a long period suddenly responded selectively.

The chronology intensified this question. Registration for the lottery procedure had taken place on 1 April 2026. The automated confirmation stated:

> *"If we are able to offer you a place on the waiting list, we will contact you within the next two weeks. You will receive a response with further information about the next steps. If you do not receive a message from us within this period, unfortunately we were unable to offer you an assessment place in this round."*

According to this communication, by 15 April at the latest it was reasonable to assume that no place had been offered. The author had accordingly prepared himself once again to receive no response. Only on 22 April, eight days after the deadline set by the clinic itself had expired, did an email arrive:

> *"Thank you very much for registering for autism assessment. In order to add you to the waiting list, we still require some information. To obtain this, we would like to conduct a short telephone conversation with you (approx. 15 min). During this conversation, we will ask you about your date of birth, insurance status and reason for contacting us (assessment and/or therapy), as well as several questions about your experiences of difficulties in social interaction. Please have your health insurance card ready for the conversation."*

The contact therefore deviated from the procedure the clinic itself had described. This still does not constitute proof of political intervention. It can, however, be established that access did not occur within the announced regular timeframe and that, by this point, the institution already knew that the case was being observed judicially, politically and scientifically.

This was more than a formal irregularity. The lottery procedure had created a clear temporal expectation for those affected: anyone who heard nothing within two weeks had been eliminated. The subsequent contact showed that this seemingly unambiguous rule was in fact permeable. The boundary between selection and non-selection was less fixed than it had been presented to applicants. This also made visible that the procedure was shaped not only by chance but by internal processes unknown to those affected.

For the author, however, the message initially had only one meaning: after years of failure, there was for the first time a real prospect of recognised assessment.

In order to be admitted to assessment, he had to call a specially activated telephone number at a fixed time. As later became apparent, this led to a phone box at the end of a corridor, where only at the specified time would a person answer the receiver. The number functioned exclusively within the designated time window. A missed call might have meant losing again the access that had only just been achieved. At least, this was the subjective fear. What organisationally appeared to be a short and uncomplicated initial contact thereby became a substantial burden for the author.

He barely slept the night before. The fear of missing the time window by a few seconds dominated the entire morning. He repeatedly checked the clock, placed reminder notes in several locations, and tried

to ensure that no thought, distraction or brief blackout could cause him to forget the call. Already an hour before the appointment, he sat in front of the telephone and repeatedly looked at the clock.

This reaction was not merely an expression of general nervousness. It arose from the objective significance of access. The author knew that behind this short telephone call stood not merely an ordinary medical appointment. Ongoing social-law proceedings, a possible higher degree of disability, accommodations, participation benefits, and recognition of a life context that had remained unexplained for decades depended on the assessment. At the same time, he knew that a new opportunity might not arise for months or years.

Already at this point, a fundamental problem of scarce diagnostic provision became visible: the rarer access is, the more strongly every individual organisational action becomes charged with existential significance. A short telephone appointment that, in a functioning healthcare system, would hardly be more than a formality becomes, under conditions of extreme scarcity, a test in which, at least subjectively, a minor error can mean the loss of an access opportunity that can scarcely be repeated.

But how is someone supposed to behave normally in an assessment under such pressure? To assume this at all appears scientifically problematic.

When the call took place, a woman answered who later turned out to be a student assistant. She asked for the health insurance card, date of birth and other basic details. The author was then asked to indicate on a scale from one to ten how urgent his concern was. He answered ten, the highest possible level of urgency.

According to his memory, the questions announced in the email concerning his experiences of difficulties in social interaction were not asked. This irritated him. The conversation had admittedly been explicitly announced only as a brief organisational pre-screening. Nevertheless, the question arose as to what function the urgency rating and the announced substantive questions actually had in the selection process and what information about the author was already known at that point.

This uncertainty could not be separated from the institutional history. The university outpatient clinic already knew about the lawsuit. The leadership knew the preceding study. The President of the university and Prof. Dr. Isabel Dziobek had been contacted personally. The Senate, commissioners and international bodies had been informed. The author, by contrast, did not know who within the clinic had received which information about him, who made the decision concerning his admission, and which persons would later be involved in the overall diagnostic assessment.

Already here one can see how strongly the setting of an outpatient clinic or psychiatry can draw a person into an entirely different interpretive context. Having previously appeared as a public critic, the relations now reversed completely.

This was an extremely unfavourable situation and psychologically highly stressful for the author. Humboldt now behaved as though the institutional history were unknown to it; to the author, this appeared like a deliberate staging of ignorance. What does this mean concretely? As later became apparent, the history was known to several people within the clinic. Nevertheless, it was initially not addressed. Whether an explicit internal decision had been made about this, or whether it remained

unaddressed for other reasons, is unknown. In any event, the procedure was conducted as though neither the preceding lawsuit nor the institutional conflict of interest had existed.

By virtually erasing the preceding drama in this way, Humboldt marginalised the author. The only recognisable response to the first paper consisted in the later invitation to assessment. The procedure was then formally begun as though there were no institutional history. To the author, this appeared like staged ignorance. The author shifted from a position of apparent power into one of vulnerability.

This gaslighting was also experienced by the author as such. He began to doubt his own mind. His own perception.

A substantial epistemic asymmetry had therefore already arisen before the first assessment appointment. The institution could possess information about the author without disclosing which information was circulating internally. The author, by contrast, had to entrust himself to a procedure whose personnel and institutional conditions were only partly known to him.

The keyword "**trust**" is central here. As is the question of what of this may later have influenced the assessment.

This was not merely a question of subjective discomfort. Diagnosis depends substantially on the assumption that observations and evaluations arise under sufficiently controlled conditions. If the diagnosing institution is already engaged in a public conflict with the person being assessed, this assumption is destabilised. The question is then not only whether individual diagnosticians act consciously in a biased manner. The unresolved state of knowledge itself already changes the setting.

At first, the author did not know whether the diagnosticians had the study. He did not know whether they were aware of the direct criticism of Prof. Dr. Dziobek. Nor did he know whether the leadership would be involved in the later case discussion and to what extent the announced video recordings could be viewed.

Because the author had to consent to video recording, despite the privacy statement he did not really know who might possibly observe the recordings or later access them. In the already conflict-laden situation, he even developed the fear that Prof. Dziobek might directly observe the procedure. There was no evidence for this assumption; it does, however, document how strongly the lack of transparency had already damaged trust in the setting.

The clinic controlled essential conditions of the procedure: access, the setting, internal distribution of information, video recording and the final formulation of the diagnostic report. For the author, this created the impression that the institution also wanted to keep the further course of the conflict under its own control as far as possible. Whether this was actually intended remains open.

From the author's perspective, given the preceding lawsuit, the public criticism and the announced further documentation, the clinic had a substantial institutional and possibly also legal interest in how the procedure unfolded.

The institution, by contrast, knew that the author was not merely a patient. He was plaintiff, critic, author of the preceding study and observer of the procedure. He had announced that he would

scientifically document Humboldt's response. Two sides therefore encountered one another while simultaneously investigating each other.

It was therefore also unclear whether Humboldt deliberately chose a "safe procedure", meaning methods through which it would not expose itself. It was unclear whether the brevity of the procedure might also have served to offer the author as little scope for attack as possible.

What matters is not whether this was the case, but that the possibility of such confusion was not handled transparently. Everything happened behind closed doors.

The clinic was supposed to assess the author diagnostically. The author investigated how the clinic would treat him under conditions of public criticism, political attention and known health risk. At the same time, other institutions – courts, Senate, commissioners and public prosecution authorities – knew about parts of the conflict and observed it in their own respective ways.

Everyone observed everyone. Everyone kept files, made notes or generated documents. Essentially, the setting of a grotesque theatre.

This nesting of observation was of course not without effect on what followed. It meant that the assessment could not be understood as an isolated clinical encounter. The procedure was already part of a political, legal and scientific conflict. Nevertheless, this conflict was not openly discussed with the author. At least not initially.

The procedure was formally begun as though it were an ordinary, unburdened diagnostic situation.

This was precisely where the first scientific and ethical problem of the actual diagnostic procedure lay.

It can be noted that this investigation too, conducted by the author, contains substantial subjective dynamics. That is true. But at the same time, it is scientifically extremely fruitful. That is: for the first time in this form, it reveals certain insights that would not have emerged without this provoked empiricism. It is the task of the research community to place this appropriately.

The institutional history did not disappear because nobody spoke about it. It remained in the room. This created the appearance of neutrality without examining the conditions of that neutrality.

One possible solution would have been to name the conflict openly, make the internal state of knowledge transparent, and refer the author to another diagnostic centre. According to the documented organisational structure, Humboldt distributed applicants not exclusively to its own outpatient clinic, but also to other institutions in Berlin. There was therefore, at least in principle, the possibility of institutionally separating the diagnostic examination from the clinic that had directly been criticised. Whether this possibility was examined in the specific case is unknown.

This gives rise to a hypothesis that cannot be proven but is raised by the constellation: whether the leadership had an interest in keeping the procedure within its own institutional responsibility. The available documents do not permit any finding concerning intent.

The question remains whether it was more important to retain control, meaning to have a say in the author's diagnosis, or whether concern about bias influenced the assessment. For one thing was already clear here. If the clinic were to decide on the diagnosis of what was at that time probably its sharpest

public critic, then regardless of the actual diagnosis there would always be the danger that this would be perceived as revenge or defence, even as the stigmatisation of a human-rights activist in the field of Critical Autism Studies. Even if Humboldt had not intended this, it might nevertheless have produced precisely this effect through the diagnosis. This should also have been clear to the President of the university.

The author does not allege any direct intention here, but simply asks whether this should not have been recognised and why no different course of action was taken.

Access had therefore been achieved. At the same time, a procedure began whose independence had remained unresolved from the outset.

If one considers the author's research work in the field of autism alongside that of Prof. Dziobek, it becomes apparent, ironically, that two camps within autism research were also represented here. There was therefore also epistemic competition. In their research, the two sides represented fundamentally opposing conceptions of autism on many levels.

The whole thing had something of a strange wrestling match over epistemic interpretive authority.

3. The First Diagnostic Appointment

On 1 June 2026, the first diagnostic appointment took place at the Special Outpatient Clinic for Social Interaction at Humboldt University of Berlin in Adlershof. According to the prior announcement, the diagnostic procedure was to consist of two appointments, a first of approximately six hours and a second of approximately four hours. In fact, the first appointment was ended after about four hours because the diagnostician responsible had another appointment afterwards. The second appointment lasted only about three hours. The assessment thus already began under a temporal compression that was not incidental to what followed. A life context spanning more than five decades, including a thirty-year history of work and artistic production with high relevance to autism, was to be captured by different diagnosticians, separated from one another in time and space, within a few hours, organised differential-diagnostically and transformed into a clinical judgement.

Each individual diagnostician saw and experienced the author only within an extremely short time window. Notes were made that were not reviewed until six weeks later in a team meeting.

It should be mentioned here that Prof. Dziobek stated in a lecture available on YouTube (*DPtV-Symposium 2025 – Lecture Prof. Dr. Isabel Dziobek*, uploaded 3 July 2025) that, for reasons of thoroughness, approximately five appointments were arranged with patients. Here, however, there were only two, if the final feedback meeting is not counted.

The first appointment was conducted by two diagnosticians. One was clearly older, the second appeared to be in her early thirties. The older diagnostician (around 60) conducted most of the conversation, while both continuously took notes. The first appointment was concerned primarily with anamnesis and differential diagnosis.

The author initially answered questions on a tablet in two rounds. Parts of these questions were subsequently asked again in the direct interview. Such an approach (multimodal assessment) can serve to make differences between standardised self-report and clinical interview visible. For the author, however, it remained largely invisible which hypotheses arose from his answers, which statements were regarded as particularly relevant, and how the two diagnosticians weighted their observations in relation to one another.

From his professional experience, however, he naturally recognised which differential diagnoses were being pursued along ICD-10 lines.

Already upon entering the clinic, he was simultaneously in a state of considerable tension. For him, the diagnosis did not have merely identity-related significance. Ongoing social-law proceedings, possible accommodations, a reassessment of decades of employment difficulties, and the hope of finally seeing a life context recognised in a form that could also hold up before authorities depended on it. He was suffering from massive symptoms of what he believed he recognised as autistic burnout.

The author therefore experienced even the greeting as a form of scanning. He recoiled slightly, remained standing stiffly and initially did not offer his hand. What from the outside might have appeared like a minor social peculiarity was, for him, part of a more comprehensive physical tension. At the same time, he tried to control the situation, read the diagnosticians' reactions, forget nothing essential and not be overwhelmed by the significance of the appointment. Precisely because of this, he repeatedly lost track of things concerning himself that he had actually wanted to raise. A fundamental problem of diagnosis.

When he opened a carefully organised folder containing documents, the older diagnostician remarked:

> *"I can already see that you are not someone who easily loses things."*

The remark was casual, but it already illustrates a fundamental problem of diagnostic snapshots. The visibly structured material could be read as an indication of particular organisation and reliability. What initially remained invisible was the effort through which this organisation had been produced, and the function it served in dealing with stress and fear of losing essential information. A compensatory system can easily appear in the diagnostic setting as counter-evidence against precisely the difficulty it compensates for.

The author already had an ADHD diagnosis. Whether the folder was now a consequence of ADHD or autism was merely one of these easily confused relationships.

Shortly afterwards, the author made the statement mentioned above concerning 27 years of extensive unemployment while simultaneously working an unpaid 40-hour week in art and research for almost three decades.

This caused the diagnosticians to pause. They had apparently not expected it. The older diagnostician asked how the author had managed this for such a long period. He explained that for a time he had lived from an inheritance and later, for well over a decade, from social assistance (*Bürgergeld*).

He had also experienced corporal punishment in English schools, as well as massive violence within the *Bürgergeld* system.

He described a childhood scene in which he was summoned to the headmistress's office and was expected to betray other pupils. He had to choose between the cane on the right-hand side of the headmistress's desk in an English school and a bowl of sweets on the left. The author said that, as a consequence, reward had always remained suspicious to him. He did not want to allow himself to be corrupted.

The patient did not arrive at the appointment as an empty carrier of symptoms from whom the professionals first had to extract knowledge. He arrived as an *evidence-bearing patient* who presented already organised, published and predominantly externally verifiable long-term documentation. A thick folder, three papers, three of his own published books, two of them on autism, as well as a licence to practise in the field of psychotherapy under the German *Heilpraktikergesetz*. Around 1,000 pages of evidence were presented.

The questions that now followed in the anamnesis and differential diagnosis concerned, among other things, narcissism, compulsions, anxiety disorders, depressive symptoms and personality disorders. In the author's impression, a substantial part of the conversation focused on distinguishing between depression and exhaustion. Initially, this gave him the impression that a classical depressive disorder was more likely being ruled out.

The diagnostician remarked (memory protocol):

> *"You do not seem depressed to me."*

The author replied (memory protocol):

> *"No, I am not prone to depression. I am massively exhausted. I do not become depressed when I can immerse myself in my work, in my special interest. That gives me energy. The greater the crisis, the more deeply I immerse myself in the work. So there are neither depressive feelings nor emptiness. There is no emptiness. Nor is there hypomania. No up and down either. It is consistent, highly concentrated work on factual problems. For 30 years, without holidays, basically all the time."*

Exhaustion did not mean that interest, will or cognitive activity disappeared. Rather, he lost the ability to cope with demands outside his own context. Precisely the work on his oeuvre (and the 27 years of extensive unemployment associated with it) could persist as the last remaining form of regulation while administrative tasks, social obligations and externally structured activities collapsed. (Special interest.) An assessment that automatically counts high productivity against severe exhaustion or disability would therefore miss a substantial part of the functional profile. The dangers had already been addressed beforehand, see Appendix 1. The author also noted that what he found extremely difficult above all was stopping, or being distracted from this work, as well as rapid switching.

What drove him was the content of his work. External recognition could play no role if he was to be able to do this work at all. It was about truths, patterns, structures, scientific puzzles, artistic expression, identifying problems. Anyone who knew his work could not overlook this.

To make this structure visible, the author had brought three of his books with him: *Speeds Arbeit*, *Denn sie können nicht verstehen* and *Radical Worker*. He placed them on the table during the conversation and explained that he had written about self-determined work because he himself could not work in any

other way. His purpose was not merely to display publications as achievements. The books were intended to document a way of thinking and working that had remained stable over decades. Thus, around 1,000 book pages were sitting on the diagnostician's table. They were diagnostically highly relevant, meticulously organised traces of data.

He also handed over a letter of recommendation from Prof. Ernst-Ulrich von Weizsäcker (Vice-President of the Club of Rome), containing a positive quotation about the author's work. The author said (memory protocol):

> *"I am giving you this so that it is documented that the research I do is not private research in the sense of a delusion or some kind of nonsense, but is real and is therefore actually received by people in research."*

That the author happened to cite one of Germany's most prominent scientists as an example had less to do with self-aggrandisement than simply with the absence of other documents. It served most pragmatically as a reference when, like the author, one had no university degree, was self-taught and therefore had no status. The author therefore feared that his work would not be read and, in the worst case, would be dismissed as confused rambling.

Speeds Arbeit was of particular importance in this context. The book, more than 500 pages long (difficult to explain through ADHD alone), documented over many years and in immense detail conflicts with authorities, poverty, institutional violence, health consequences and the continued theoretical processing of these experiences. For the author, the diagnostic relevance lay precisely in the connection between two apparently contradictory facts: for around 27 years he had been almost completely excluded from regular employment, yet during the same period he had worked on an extensive body of work at an almost full-time level. He treated it like a full-time job. And had one not known that he was completely impoverished, few people would probably have noticed any substantial flaws in the work itself beyond the usual criticism among researchers.

The production of the oeuvre was therefore so much more decisive for assessment than the information that someone was, for example, a baker or an engineer, because the work contained an extremely high proportion of patterns read as autistic in research. This was what the author repeatedly pointed to. The diagnosticians, however, seemed to treat it more as though the person simply wanted to keep talking about his own job, as if it had no place here. As though it were unwanted infodumping.

Because the author happened to be an artist operating in public, everything he submitted was indirectly also a presentation of status. And precisely this collided with his actual status as an unemployed person.

This led to a substantial problem. The more the author pointed out that they should look at his work, which from his perspective was highly autistic, the more this was read as an attempt at self-importance.

The author could work, but not arbitrarily. Under self-determined conditions, he could develop extraordinary endurance over years, while institutionally prescribed, fragmented or, to him, meaningless work structures repeatedly led to loss of functioning. This difference was one of the reasons why he regarded the autism hypothesis as having strong explanatory power. It could not be captured by merely establishing that a person was productive or possessed high linguistic and cognitive abilities.

According to the author's recollection, the diagnostician took the books in her hands and initially noted that they had been self-published. For him, this was not an insignificant detail. He knew the recurring experience that, with his work, people first asked about institutional status, publisher, position or academic affiliation, and only afterwards, if at all, about the content. In the concrete situation, this therefore immediately produced the concern that the work might be perceived less as biographical and diagnostic evidence than as self-published self-presentation.

It should also be considered here that neurodivergent people, especially autistic people, are often rejected by conventional publishers precisely because they have a completely different way of writing that can be unbearable for neurotypical readers.

The author had tried to explain this through an account of a conflict with an editor at Fischer Verlag. According to the editor, the author had forced massive amounts of factual detail into a novel and refused to smooth it into a marketable form. *(Novel: Stieren des Weltdesigners.)*

The author then said himself (memory protocol):

> *"You see, I have no status. It is about the content. That is what I live for."*

The observation that the books were self-published does not in itself prove devaluation. It did, however, encounter a life history in which the lack of institutional status was precisely part of the problem requiring explanation. The work had emerged over decades even though no publisher, university or regular employer supported it. If precisely this lack of institutional recognition were now used to reduce the epistemic value of the material, a closed circle would arise: the work did not count as full evidence because it had been produced outside recognised institutions; at the same time, the lack of institutional integration was to have hardly any diagnostic significance.

The diagnostician eventually explained that she did not yet know whether she would have time to look at all of the material. Testimonial injustice threatened.

In this sentence by the diagnostician, a fundamental contradiction of the procedure became visible. The diagnostic decision was explicitly supposed to emerge from an overall assessment. At the same time, already at the first appointment it was unclear whether the most extensive and longest-documented evidence in the case could be read at all. Even though the author published on autism.

The problem was not that every diagnostician would have to work through several thousand pages in full. But it did need to be clarified which parts of the material were examined, according to which criteria they were selected, and how the unexamined parts would be taken into account in the later statement about the overall picture.

Otherwise, a peculiar reversal threatened: it was not the available material that determined the necessary scope of the investigation, but the predetermined time frame that determined which reality could count as diagnostically usable.

But how, then, were five decades to be represented when they had been shaped substantially by everything revolving around this body of work?

This led to the paradox that the author's oeuvre, as documentation spanning 30 years, together with the author's public autism research, represented a far more substantial accumulation of evidence than

the diagnostic setting itself. This was a considerable scientific problem. For in all fields of research it is regarded as problematic to prefer an assessment based on less evidence over one based on substantially more. But then the patient would have had to be recognised as an expert in his own field. Certainly, there would still be the question of quality, but precisely this was apparently not examined, because the more extensive evidence was epistemically devalued in order to protect the institution itself from overload, as later became increasingly apparent. The health insurer, through the diagnostic budget, determined what evidence could be integrated, not the scientific conscience of the clinic.

It may be that in children and young people autism can primarily be recognised through clinical observation. In 50-year-olds, the question arises whether it does not manifest itself much more strongly in life, in the biography of those affected, and whether this should not be the actual primary source. The idea that actual life experience should play hardly any role in diagnosis later in life is questionable.

In addition to the books, the author now left several scientific texts at the clinic. These included *Thinking in Formation: On a Form of Cognition That Produces Knowledge in Process* (Speed 2026) and *Work under Eigenzeit: On the Structure of Eigenzeit-Based Binding and Its Incompatibility with Functional Work Regimes* (Speed 2026). Both works directly examined precisely the mode of thinking and working whose diagnostic significance was to be clarified in the conversation. In addition, there was *A General Theory of Masking*, a paper with which the author particularly wanted to relativise the strong orientation towards Theory-of-Mind models and describe different orders of relevance in neurodivergent communication.

In doing so, the author intended to relativise what he regarded as the strong weighting of social deficits apparent in the Humboldt clinic and to place autistic experience more strongly at the centre, rather than basing diagnostic judgement primarily on behaviour observable from the outside. International research shows different theoretical and diagnostic emphases here. While social-cognitive deficit models and Theory-of-Mind approaches in particular continue to be used strongly in Germany, concepts such as the Double Empathy Problem, masking and camouflaging have gained greater visibility in the Anglo-American discourse. The author therefore wanted to introduce a perspective that does not understand social interaction exclusively as a unilateral deficit of autistic people, but also takes into account reciprocal problems of understanding, compensatory efforts and the internal burden of social adaptation.

He also submitted his school-leaving certificate, which showed him as a school dropout who later completed the *Matura* (*Abitur*) externally, and evidence of his authorisation to practise psychotherapy under the *Heilpraktikergesetz*. He had obtained this in the context of his research in order to be permitted to work therapeutically with people, but was later always paid by patients only in eggs and cakes, which was why he did not develop the practice professionally. He nevertheless had considerable experience in the field of psychotherapy. Through this, he wanted to make clear that his social reciprocity could not be considered outside all learning and professional history. For years, he had engaged professionally with psychological processes, communication and the effects of language. The fact that he was able to speak in a differentiated way and respond to an interlocutor in a clearly structured diagnostic situation therefore could not be evaluated independently of this experience.

There are not few autistic psychotherapists worldwide, which should also give one reason to reflect on autistic people's ability to respond empathically to other people. As an intellectual and as part of the art scene, the author was naturally highly experienced in dialogue and discourse, appeared on panels, spoke at conferences and knew how to express himself. It later seemed strange that the clinic assumed that such profiles could not also be autistic, as though intelligence and learning ability had practically no effect at all.

Here, the central difficulty with late-diagnosed adults who compensate strongly intellectually and linguistically was already apparent. The diagnostic procedure observes a person in an artificially created situation. It sees the outcome of decades of learning, but not automatically its costs, conditions of emergence and limits. Precisely the abilities that were developed in order to control social uncertainties can later serve as evidence that those uncertainties had never existed.

The author had appeared on many stages, but repeatedly failed because he irritated audiences through breaking social norms. He spoke things very directly and followed literal logic. In Italy, he destroyed the opening conference of an innovation centre in this way. On the one hand massively overstimulated and distracted by the spotlights, he lacked all business-like smoothness and argued in a jumpy and excessively detailed manner. It was basically paid infodumping, which was why he mentioned to the diagnostician that he was often interrupted with accusations of mansplaining and always needed a lead-in before getting to the point.

Humboldt could have obtained this kind of information from the author's body of work.

During the conversation, it remained unclear to the author to what extent the diagnosticians recognised these connections. He perceived changing reactions: irritation at the quantity of material, interest in individual points, but also limitation by the prescribed procedure. This reinforced the feeling that although the evidence was physically present in the room, it was not yet certain whether it would receive a place within the diagnostic order.

In addition, such an existentially charged situation would make even a university professor stumble over their words. ADHD did not exactly help the author explain and present everything appropriately on site.

Finally, the differential diagnosis ended with an apparent focus on depression or burnout, while the diagnosticians gave no insight into their reasoning.

Despite the author's traumatic experiences, from his perspective there was no sufficient clarification between trauma-related consequences and autistic symptomatology. PTSD did not appear to have been seriously addressed, although the author stated that receiving *Bürgergeld* was basically like war.

It could have been fruitful to distinguish autism from this by clarifying more precisely, for example, when exactly which symptoms first appeared. It might then have become visible that the apparently autistic ones had all been present long before the traumatic experiences.

But not a single question was asked about what receiving *Bürgergeld* concretely did to him.

Then, however, another decisive moment occurred. The older diagnostician revealed her insider knowledge:

"I was told that you sued the clinic."

According to the author's recollection, she smiled slightly as she said this and asked whether he could explain why he had done so.

This created a very strange atmosphere. What was perhaps the most important information for the entire setting arrived at the very end of the differential diagnosis. The author was thereby told that the diagnostician must already have formed some picture beforehand. At the latest now, her colleague also knew about it.

The situation had forced the author himself to behave as though he knew nothing. Because he did not know whether the diagnosticians were informed. Consequently, he could not say whether Humboldt had selected him because of his lawsuits and the public pressure. But since apparently everyone now knew, it was clear that the case had been communicated within the team beforehand by Prof. Dziobek. It can be assumed that some form of devaluation may have occurred unconsciously in this process. The clinic had obviously adopted a position of self-protection. The setting therefore now felt like gaslighting.

This means that the author was forced not to behave naturally. Cynically, the older diagnostician had said at one point during the appointment (memory protocol):

"You do know, Mr Speed, that you do not have to pretend with us."

This statement now seemed all the more disturbing.

The question of why he had sued Humboldt now operated in two directions. On the one hand, it appeared to be a question that had diagnostic value for the person asking it. At the same time, it was possibly also an institution speaking that might have wanted to gain a strategic advantage in the court proceedings from the question. This experience substantially unsettled the author.

The author explained that the lawsuit belonged within the context of his research. He examined processes involving authorities, courts and companies not only retrospectively, but placed institutions through applications, complaints and proceedings into situations in which their structures became visible under pressure. (Provoked empiricism.) The lawsuit had therefore been both an attempt to obtain necessary diagnostic access and an empirical investigation of a system blocking this access for thousands of people.

Within the "overall picture", this produced an extremely surreal scene. It must have appeared so bizarre to the diagnosticians that later interpretations of self-aggrandisement become recognisable here as a confusion.

Had the public body of work of the author been engaged with, it would have been possible to read online that this was how he worked as an artist and researcher, and that this constituted a legitimate form of intervention that the author called "provoked empiricism". Because this was not done within the context of the conflict, perhaps because the author was also unconsciously regarded as an opponent, there was no intellectual understanding of the author's working method, whereby "crazy things artists do" moved ever closer to pathologisable assumptions.

It was internationally known and recognised that the author provoked institutions in order to derive insights from this that were then processed in art and research. This paper also emerged in this way. It was stated on the website and could be read in various places online, as well as in the books he had submitted. It was therefore a highly professional activity requiring a learned craft.

Cultural practitioners in particular are trained to do precisely such things. This is also why artistic freedom exists.

The diagnostician initially displayed the practised look of a therapist interested in the motives behind the lawsuit. The author then once again explained his central criticism of the lottery procedure. The actual figures – in the documented quarter, 1,667 applicants for approximately 25 places – needed to be published on the website. Otherwise, those affected could not realistically assess their chances. At the same time, disclosure would generate political pressure because the diagnostic shortage could then no longer be concealed through general formulations about long and confusing waiting times.

According to the author's recollection, the diagnostician received the criticism openly and stated that she intended to pass it on to the leadership. Yet something like a bruised institutional ego remained. Naturally, this was the author's subjective perception. There was, however, considerable effort to point out comprehensively everything the clinic did for those affected. At times it sounded like a sales pitch in which the diagnostician was supposed to make the author understand that the clinic was not so bad and that the author did not need to make such a fuss out there.

The institution justified itself.

Of course, this is an interpretation, but the question remains why it was considered important to give the author, at the end of an assessment, a short lecture on the ethical standards of the clinic while simultaneously diagnosing him.

The author did not dispute the clinic's commitment. Precisely in this, however, he saw part of the political problem. A highly committed and publicly recognised specialist clinic could serve as evidence that the system was taking care of people, even though thousands continued to have no realistic access. Attitude did nothing to change the suffering of people who could not obtain access to assessment.

The discussion became political. One can see in this that both sides were struggling over positions.

Institutional performance and structural failure did not exclude one another. They could even stabilise each other. The more visible the commitment of an individual clinic became, the easier it was for politics to point to this commitment without fundamentally changing overall provision. The institution could, according to the author, do a great deal and nevertheless remain part of a structure that normalised scarcity.

The first appointment therefore ended in a peculiar form of competition. The diagnosticians had asked numerous questions and produced extensive notes. Books, certificates and papers had been handed over. At the end, the author also left a copy of his feature film *Transferprotokoll*, which would later play a larger role in the assessment.

The lawsuit and the criticism of the lottery procedure had been explicitly discussed. At the same time, the author did not know how his material would be read, how his statements would be condensed internally, or which persons would be involved in the later decision.

The procedure had begun, but the image emerging from it remained invisible to the person being assessed.

Already here, the asymmetry that would become decisive in the further course was apparent: the diagnosticians could continuously test, modify and stabilise their hypotheses in their notes. The author, by contrast, could only hope that his statements were received in the form in which he had intended them. Precisely this capacity for judgement, however, had become massively questionable because of the history of the procedure.

No systematic possibility to inspect the emerging interpretation and correct it at an early stage was provided for within the procedure.

4. The Second Diagnostic Appointment

The second diagnostic appointment took place on 4 June 2026. Thus, three days later. It lasted approximately three hours in total and consisted of two clearly separated parts. In the first, the ADOS-2 was conducted; in the second, a more in-depth interview followed concerning childhood, development and biographical course.

This was the absolute minimum for an autism assessment, if not clearly too little.

It can be assumed that this diagnostician also knew that the author had sued Humboldt. After all, the information had already been handled quite freely.

This was also because, weeks earlier, the author had informed everyone on the team whose email addresses were publicly available about the study in a circular email. One diagnostician remarked that she had seen the author's books somewhere before, but could not remember where. This was presumably because, weeks earlier, she had clicked on the website link in the email, where the author's books appeared on the homepage. Put casually, by the time of the assessment, half of Humboldt knew that the author had sued the university and that this study existed. The probability was also high within the university leadership. None of this is proven, but Humboldt should have taken into account that this possibility existed.

Now the ADOS procedure began in another new room, with another diagnostician different from those before.

The ADOS-2 is a standardised observational procedure. The person being assessed is confronted with various tasks and conversational situations, while the diagnostician observes in particular communication, social interaction, imaginative abilities and other behavioural characteristics. Some of the individual tasks appear playful or artificial. Their diagnostic significance lies less in whether a task is solved "correctly" than in how the person being assessed engages with the situation, the material and the diagnostician present.

For the author, precisely this constituted a fundamental problem. He knew that not only his answers, but also eye contact, gestures, conversational flow, reciprocal response and the apparent naturalness of the interaction would be evaluated. He therefore once again entered a paradoxical situation: he was supposed to behave as spontaneously as possible, while at the same time knowing that every reaction could be observed, coded and later interpreted diagnostically. The author had published in research on the history of ADOS and essentially knew the methodology. He knew that Catherine Lord had led the group that developed ADOS at the time. He knew the entire history and large parts of the procedure, including the scientific criticism associated with it.

Especially in the case of a person who had spent decades engaging with psychology, social communication, masking and diagnostic procedures, the idea of uninfluenced spontaneity was hardly sustainable. Humboldt knew this too. ADOS should therefore actually have been declared invalid.

The author was dependent on the procedure and therefore could not raise a direct objection. He did, however, inform the diagnosticians that ADOS was unsuitable for his profile. He presented the book in which he had, among other things, published about ADOS. By presenting his book *Denn sie können nicht verstehen – Warum die Autismusforschung irrt*, he stated that he knew the field as a researcher. The diagnostic team completely ignored this.

Thus, despite comprehensive knowledge, they ignored that the examination could not be valid.

As a 53-year-old with giftedness, the author belonged precisely to the group that research documents as often not being recognisable as autistic in ADOS. Prof. Dziobek had apparently decided here — though it is not exactly clear who made the decision — to carry out the standard procedure regardless of the losses.

Among the tasks was the usual picture story with flying frogs from the book *Tuesday*. The author described the sequence largely matter-of-factly: the frogs flew, moved on, watched television and then disappeared again. He did not develop a strongly emotionalised or embellished narrative from this, but described what happened in the pictures.

Another task consisted of a crowded picture showing a map of the United States with numerous figures and symbolic representations. The author initially did not recognise that it was a map. Instead, he saw individual figures, each isolated and engaged in their own activity. (Bottom-up.) He described them as “egomaniacal figures”, each doing their own thing alone on an overall surface that he had not yet recognised.

This reaction later seemed remarkable even to him. He was surprised that he had not recognised the map, which is not untypical for autistic people, although, like everything in the procedure, it proves nothing by itself. He did, however, show a mode of perception that initially proceeded from details and the relationships between individual elements, while the overarching form only became recognisable with delay. The detail emerged before the overview. The task had therefore not simply been solved incorrectly or unusually. It produced a concrete example of how the author initially structured visual and social arrangements locally before an overall form emerged.

When demonstrating toothbrushing, he explained relatively matter-of-factly how he systematically proceeded from tooth to tooth. Here too, there was no strongly performative presentation, but rather

an ordered description of a sequence. Apart from this, the author was also an actor, which Humboldt knew. In this respect, this presentation too was distorted.

In a geometrical task, individual pieces were to be assembled into a figure. In the author's view, four elements did not fit meaningfully into the intended form. He therefore placed them outside it. His decision followed an internal structural logic: if the pieces disturbed the geometry of the figure and made no sense within the form, they should not be forced into it. He had to put them elsewhere in a somewhat compulsive manner.

Precisely this reaction points to a recurring mode of thought in the author. A formal expectation was not fulfilled merely because the task apparently demanded it. What mattered was whether the solution remained coherent within the perceived structure. Pieces that did not fit were not made invisible through adaptation or improvisation, but left outside the figure as non-integrable.

Another task consisted of developing a story from small objects. The author selected a yellow feather, a yellow cube, a wooden stick and a paper clip. In his highly abstract story, the feather asked what the objects had in common. The paper clip was brought in to help solve the problem. It could, however, see only two-dimensionally and therefore failed to recognise the cube. The feather explained to it that the cube was yellow and that the paper clip had to accept that not every object could be fully recognised by every other object.

There was no psychological or emotional dimension in this whatsoever. The story was told as an experimental arrangement structured by logic. Beyond that, it reflected the setting.

This story too was not arbitrary. It took up a problem that ran through the author's entire body of work and the current diagnostic conflict: different epistemic access points, limited perspectives and the impossibility that every form can directly apprehend every other form. From an apparently playful task, another narrative about epistemic difference thus emerged.

It must be said that the author had been trained as an artist to express such stories and relationships spontaneously. This requires years of practice and training. What one intended to infer from this using a methodology for children remained questionable.

Humboldt also knew that the author had published a novel that would in turn have been diagnostically highly relevant. No interest.

The author nevertheless did not know to what extent such content was evaluated at all. In the later report, the particular structural decisions, detail perception and epistemic form of the story were not foregrounded. What mattered above all was how he interacted with the diagnostician during the tasks. The evaluation focused on communication and social reciprocity, not on the possible cognitive patterns revealed in the processing itself.

As stated, there are very, very many autistic actors who can perform roles on command that reveal no autism whatsoever.

The author's situation, which the clinic knew about, could no longer possibly appear authentic. It would therefore have been necessary to shift from external observation to substantive engagement. If a

dead fly is stuck on the lens of a microscope, what can still be seen of the sample can no longer be regarded as scientifically usable.

Through the use of ADOS, a selection was therefore already made within the procedure that functioned like a filter. What was filtered was not autism, but a particular profile often associated with autism, one that clearly does not exclude autism.

The material contained several levels: the concrete solution, the mode of perception, the structure of the narrative, the reaction to incoherence and the social interaction occurring at the same time. The diagnostic framework, however, did not weight these levels equally. It privileged those observations for which ADOS provided standardised categories.

The test therefore did not simply see what the author did. It saw primarily what its categories were able to make readable from his behaviour.

As stated, the author was 53 years old, highly differentiated linguistically, and had spent decades engaging with human communication, psychotherapy, art and institutional conflicts. He knew how conversations were conducted, how reactions were read and how uncertainties could be concealed. He himself had therapeutic experience as a practitioner.

The central question was therefore not whether he could maintain a reciprocal dialogue for several hours. The question was at what cost this occurred, how stable this ability was outside the test situation, and why, despite being situationally visible, it had not translated into sustainable social and occupational integration. Why, then, did the author fail everywhere in social communication? The fact that he directly sued Humboldt, thereby simply overriding all social norms and conventions, annoyed the Senator and advanced without a lawyer all the way to the Federal Constitutional Court in order to make a fundamental injustice public through massive detailed work, should also have given Prof. Dziobek reason to reflect. None of this was untypical for autistic people.

It is important in this investigation to state clearly that two movements are required, but they must be separated in the evaluation. The author must clearly identify indications of autism that were present, or offered, within the procedure. For the issue here is how these indications were handled. This does not mean, however, that the author thereby introduces them as proof of autism; he introduces them as evidence that concrete indications existed. They are data, not diagnoses.

Up to this point, therefore, essentially only two diagnostic actions had been carried out. A differential diagnosis (anamnesis) and an ADOS procedure. In research, the ADOS procedure was regarded as particularly unreliable in gifted older adults. Especially when ADHD was additionally involved.

The evidential basis methodically collected by the clinic was therefore rather thin up to this point.

After the ADOS, the so-called in-depth interview followed with yet another, younger diagnostician. It concerned childhood, development and the long-term expression of possible autistic features. In this conversation, the author explicitly voiced his concern that the clinic might weight social interaction and Theory-of-Mind questions too heavily, while monotropism, object attachment and the structure of his oeuvre receded into the background.

This also preoccupied him because the person sitting opposite him was at least 20 years younger and gave him no feedback as to whether she understood his words. She simply nodded at everything. For autistic people with a life full of social misunderstandings, not knowing what the other person thinks is extremely stressful. This made the communication predictably prone to misunderstanding. Essentially, one could also regard this as a reconstruction of the Double Empathy Problem.

Damian Milton's (2012) concept of the Double Empathy Problem shifts communicative difficulties from a unilateral deficit of autistic people towards a reciprocal problem between differently organised experiential and meaning-making worlds. For diagnosis, this creates a particular difficulty: if the diagnostician misunderstands the patient's ordering of relevance or mode of expression, precisely this misunderstanding can subsequently be documented as a deficit of the patient. The institutional position then determines whose lack of understanding becomes diagnostically visible and whose contribution to the communicative breakdown remains invisible.

If one therefore expected a neurotypical presentation of autistic symptoms, precisely this could massively distort the intensity and weighting of those symptoms. The author had written an entire book on this problem (*Denn sie können nicht verstehen*), in which he introduced the incommensurability between autistic and neurotypical people with the sentence:

> *"One cannot exist and at the same time be understood."*

The author had to expend immense energy reconstructing contextualisation and presenting it appropriately. Essentially, he concentrated on nothing else anymore. Naturally, from long life experience, he knew how this internal conflict would not become visible externally. In short: he played over and covered what he said with another layer of how he said it and how he concealed his actual feelings while doing so as much as possible.

Here too one could see how Humboldt created a setting in which neurodivergent people want to conceal themselves, and they conceal themselves all the more skilfully the more experienced they are at doing so, and the less experienced the diagnostician is.

He therefore continually pointed to the fundamental mismatch between the available long-term evidence and the diagnostic format. On one side stood approximately three decades of documented work, thought and oeuvre history. On the other stood two appointments, questionnaires, standardised tasks and little time for interview. For him, the problem was not that interviews and tests were fundamentally unsuitable. It was that they could only supplement the more extensive body of material, not replace it.

By the body of material, the author meant his life itself. Apparently, something completely different was understood.

The diagnostician did not engage with this objection in depth. According to the author's recollection, she merely explained that unfortunately nothing could be done about that. She was therefore saying that nothing could be done about the fact that reality could not be represented within the procedure. This triggered a certain experience of panic in the author.

This sentence was significant in its simplicity. It did not say that the concern was unjustified. It said that the institutional framework could not be changed. A possible methodological limitation was thereby acknowledged without any consequence following for the scope of the later judgement.

It was also completely unclear whether the diagnostician had read **Appendix 1**. Her questions did not address the features listed there. It appeared that she had either not read Appendix 1 or did not consider it useful to integrate this prior knowledge into the questioning. The author inferred this from the fact that the diagnostician apparently did not know, or did not properly understand, the term "veridical mapping", which is explained right at the beginning of Appendix 1.

The author had tried to explain to her the significance of this cognitive and perceptual structure (hyper-systemizing/Baron-Cohen) within autism research, but she only kept nodding and asked no deeper questions about it, although it concerned a central element of autistic cognition.

If the procedure was unable, because of its temporal and methodological structure, to capture certain areas of life adequately, this should actually have led to a limitation of the diagnostic statement. Instead, the expectation remained that a conclusive overall assessment could nevertheless be derived from the limited procedure.

The author therefore also experienced this appointment as industrial. Not because the diagnosticians were necessarily uninterested or unfriendly, but because the process had already been fixed before anyone knew what complexity the particular case would bring with it. Tasks, blocks of questions, time windows and evaluation categories formed a production line through which different biographies were transformed into comparable diagnostic units.

A situation of massive alienation emerged.

Standardisation is necessary for diagnosis. Without common criteria, observations could hardly be compared. It does, however, create a problem when comparability becomes more important than the object itself. Then the question is no longer what form of investigation this case requires, but whether the case fits the existing investigative format.

Throughout the entire conversation, the author retained the feeling that he was able to include only a small fraction of his biography. Every answer had to compress several decades, different phases of life and recurring structural problems into a few sentences. While the diagnostician noted individual aspects, he could not see how these notes were formulated, which connections were preserved and which were lost through abbreviation.

The problem was not only limited time. A feedback procedure was missing. The author could answer questions, but could not examine what diagnostic statement emerged from his answer. He could offer additional information, but did not know whether it was classified as relevant, secondary or contradictory. The diagnosticians' hypotheses remained invisible while his statements continuously entered their model.

There was therefore no equality of epistemic means. The diagnosticians could collect observations, discuss them with one another and later revise them. The author, by contrast, could control neither the emerging notes nor their interpretation. He was present, but did not participate in the process of meaning formation.

Precisely in autism assessment, this asymmetry is problematic. Among the things being examined are communication, social meaning, perspective-taking, the ordering of relevance and biographical continuity. If differences between patient and diagnostician exist precisely in these areas, misunderstandings cannot be treated as mere background noise. They are themselves part of the diagnostic risk.

A shortened answer can be recorded as an absent feature. An inappropriately formulated question can produce an apparently unambiguous answer. An example explained later can be overshadowed by a hypothesis that has already arisen earlier. Without access and correction, the person being assessed does not know at what point the diagnostic picture begins to diverge from their actual life.

If the diagnostician is extremely young, a lack of life experience can lead to substantial misinterpretation of the life circumstances of a 53-year-old.

The scientific usability of the entire interview must generally be questioned here. How could one assume, within this overall context, that it produced authentic and specifically non-distorted evidence at all?

Even if this had not been the author, with that dramatic history, the years-long waiting period for the appointment and the lack of alternatives alone would always expose the objectivity of the measurements to distortion caused by pressure and existential need.

At the end of the second appointment, the author was informed that telephone-based informant interviews would still take place. His partner and a psychotherapist friend who had known him for many years and worked with autistic people were interviewed. The material was then to be evaluated in a team meeting. A feedback meeting was expected within approximately three weeks.

The active diagnostic examination was thereby initially completed.

The author did not, however, leave the clinic with the feeling that he had comprehensively represented his life. Rather, he felt that he had introduced a large quantity of material into a procedure without knowing which parts of it had actually been carried forward. The assessment had generated numerous data. Whether these data represented his life context or had already produced a substitute image that he could no longer correct remained open.

Another phase of waiting now began. The decision about his life shifted into an internal team meeting in which he did not participate and whose composition, materials and deliberations were not disclosed to him. The person left the procedure; his data remained behind.

Overall, the “in-depth interview” was unsatisfactorily thin. It was not an analysis in which childhood was searched through, but a cold interrogation of standard formats in a life in which, put pointedly, almost nothing was standard.

5. Informant History and Further Submissions

After the two assessment appointments had been completed, the procedure initially shifted away from direct contact with the author towards informant history and internal evaluation. The specialised

outpatient clinic announced that it would speak with his partner and with a psychotherapist friend who had known him for more than ten years and worked professionally with autistic people. Only after this was the material to be brought together in a team meeting and a diagnostic decision made.

The informant history was of particular importance in the present case. At the time of the assessment, the author was of an age at which records from early childhood were no longer available. Memories of individual developmental phases could not be reconstructed without gaps, and parents or other relatives who could reliably have reported on early childhood were not available. The question therefore became important as to how long-term patterns could at least be reconstructed from later periods of life, close relationships and years of observation.

The partner knew not only individual social situations, but the author's everyday life, his way of working, his crises, his states of exhaustion and the conditions under which he functioned or broke down. The psychotherapist friend had likewise known him for many years and additionally had professional experience with autism. Both could therefore contribute a form of long-term observation that could not be produced within the few hours at the clinic.

Precisely therein lay the function of an informant history: it was intended to supplement the clinical snapshot with experiences from everyday life. It could make visible whether a behaviour occurred only under test conditions or recurred over years in different situations. It could also provide indications of how strongly masking, compensation and situational adaptation distorted perception within a brief diagnostic encounter.

After the conversation, the partner reported that she had felt uncomfortable during the questioning. The questions had predominantly focused on deficits. This had created a picture in which she was continually expected to name problems, limitations and peculiarities of the author, while other sides of the relationship and of his person were given hardly any space. She felt inhibited by this.

This discomfort is not incidental to diagnostic evaluation. Informant interviews are not neutral windows onto a person. The form of the questions structures what can be remembered and reported at all. If questions focus almost exclusively on difficulties, failure, social inappropriateness or burdensome behaviour, a deficit-oriented dataset necessarily emerges. This may be diagnostically necessary because clinical criteria relate to impairments and symptoms. At the same time, however, it can place strain on the relationship between the person being interviewed and the patient and produce a picture shaped more strongly by the logic of the instrument than by the actual relationship as a whole.

In addition, people in a romantic relationship may tend to marginalise negative aspects. Consciously or unconsciously.

The setting artificially contextualises content, which inevitably distorts content.

The partner was thereby placed in a difficult role. She was supposed to report as openly as possible on burdensome characteristics, while simultaneously knowing that her statements would enter into a judgement with substantial health, legal and social consequences for the author. An overly cautious answer could be read as a lack of confirmation of autistic traits. A detailed description of difficulties, on the other hand, could produce a degradingly deficient image that did not do justice to the relationship.

The clinic knew that the partner had ADHD. This too played a role, although it was unclear whether it was taken into account afterwards. Particularly in the context of ADHD, assembling data contexts under expectation pressure is not unproblematic.

On 17 June 2026, the conversation with the psychotherapist friend took place. She had known the author for more than ten years, worked herself with autistic people and, according to his documentation, was also asked for a professional assessment. Her assessment affirmed autism.

She said (memory protocol):

> *"What else, other than autism! I see no other explanation."*

The specialised outpatient clinic therefore had before it not only the author's positive self-assessment. A psychotherapeutically qualified person with long-term personal knowledge and experience in the autism field likewise took the view that the autism hypothesis was correct. This assessment was not a formally recognised specialist medical diagnosis. The psychotherapist had not conducted a standardised diagnostic procedure. Her account nevertheless carried substantial weight as long-term observation and professional informant assessment. The therapist had experienced the author over years in conflict situations. From her perspective as a psychological psychotherapist, there were massive indications of autism.

According to the documentation, at least five psychotherapeutically qualified persons were involved in the procedure overall, including several professionals with doctorates. Two diagnosticians conducted the first appointment, another carried out the in-depth interview section, and another the ADOS. In addition came the psychotherapist friend and further persons involved in the team meeting or the report. Which persons ultimately participated in the decision, how their assessments were weighted, and whether Prof. Dr. Isabel Dziobek herself participated in the case discussion were not transparently disclosed to the author. She did, however, sign the report.

This lack of transparency became all the more significant the more strongly the individual sources of information differed from one another. On one side stood a few hours of direct observation by the clinic. On the other stood the author's self-reports, decades of documentation through his body of work, high screening scores, the partner's assessment and the professionally positive assessment of a psychotherapist with long-term knowledge of him.

An overall assessment would not merely have meant listing these sources side by side. It would have had to show how differences in proximity, duration, professional expertise and possible distortion were taken into account. A diagnostician who experiences a person for a few hours has a different form of access from a partner who knows them every day. A close reference person may be emotionally involved and thereby influenced in their perception. Conversely, a clinical observer may be distorted by the artificiality of the test situation, time pressure and theoretical assumptions. None of these perspectives is automatically objective. Their respective limitations would have to be treated symmetrically.

We are not speaking here about requirements of everyday clinical practice, but about scientific integrity. In the end, the latter must prevail.

In the later report, it was explicitly noted with regard to the informant history that it was based on the subjective assessment of a reference person and should therefore be interpreted in connection with the remaining diagnostic procedures. This applied even to their colleague.

This limitation is, in principle, understandable. What is striking, however, is the asymmetry that may result from it: the long-term perception of a reference person is explicitly relativised as subjective, even when that person is a professional, while the clinical assessment of the diagnosticians appears as a more neutral component of the overall assessment.

Clinical observation, however, is likewise a subject-bound interpretation. It is shaped by training, experience, diagnostic model, temporal limitation and expectations. The difference is not that the reference person is subjective and the professional objective. The difference is that the professional perspective is institutionally authorised.

Precisely for this reason, the report should have disclosed why the long-term informant observations were, where applicable, weighted less heavily than the brief clinical encounter. Without such justification, "subjectivity" becomes a label that primarily weakens precisely that evidence which contradicts the later judgement.

The associated workload must not become the determining factor in a diagnosis of such importance, or the diagnosis renders itself absurd. Clinically correct but scientifically wrong is not an acceptable condition.

The later report did not mention that the psychotherapist friend had clearly argued in favour of autism. The colleague was merely listed as an "acquaintance" and was thereby epistemically devalued. Not a word that she was a licensed psychological psychotherapist who had worked with autistic people for years.

While the informant interviews were taking place, the author transmitted further information to the clinic. This included the information that a closed fontanelle had been observed at his birth and that his head circumference was approximately 62 to 63 centimetres. These details had no unequivocal diagnostic significance in themselves. They do, however, show how intensively the author attempted to introduce even unusual biographical and physical indications into the procedure.

In addition, the clinic had earlier screening scores available, all of which pointed strongly towards autism:

- AQ: 42 out of 50;
- AQ-10: 9 out of 10;
- RAADS-R: 190 out of 240;
- RBQ-2A: 43;
- Aspie-Quiz: 161;
- CAT-Q: 167 out of 175;
- EDA-QA: 40 out of 78.

These scores were not a diagnosis. Even high screening scores can be influenced by other psychological burdens, response styles or overlaps with ADHD and other disorders. Taken together, however, they represented a strong and consistent signal across several instruments. The CAT-Q score in particular

indicated an exceptionally high degree of masking. The RBQ-2A, in turn, related specifically to repetitive and restricted patterns of behaviour and interests — precisely the area that was later assessed in the feedback meeting as insufficiently present.

The screening scores therefore did not simply have to be accepted as proof. But they created a substantial need for explanation.

If they were supposed to indicate something other than autism, then one had to be able to explain what, concretely, the individual answers supported as an alternative when the scores lay far above the cut-off.

If one mentally spreads the various questionnaires and test instruments out across the floor, an extraordinary density of questions about the life of the person concerned emerges. Taken together, they capture far more individual situations, memories, behaviours and internal reactions than could possibly be asked about within the few hours of clinical interview. The answers concerned social communication, masking, repetitive interests, routines, sensory particularities, autonomy, exhaustion and the long-term organisation of everyday life. They therefore did not constitute a single fleeting impression, but a pattern generated across numerous items.

None of these questionnaires proves autism by itself. Even high scores can be influenced by symptom overlap, psychological distress, social anxiety, negative self-evaluation or a non-specific response tendency. In the AQ, for example, ADHD and generalised anxiety can produce elevated scores.

But this does **not** mean that seven strongly elevated results from different instruments can simply be explained away with two alternative labels.

The Individual Scores

AQ 42/50 and AQ-10 9/10

These are very high scores. ADHD can increase AQ scores because some questions relate to attention, social difficulties, conversational control and organisational problems.

With **42 out of 50**, however, it would have to be shown concretely:

- Which answers are supposed to be explained by ADHD?
- Which by a personality accentuation?
- Which, by contrast, concern sensory, communicative, imaginative or repetitive features that are not readily covered by these explanations?
- How does the alternative model explain that the AQ-10, at 9 out of 10, is likewise almost maximal?

The later suggestion that “AQ can be elevated in ADHD” is correct. It does not follow from this that: “An AQ of 42 is explained by ADHD.”

RAADS-R 190/240

This score too is massively elevated. The original validation study set the threshold at 65 and reported very high sensitivity and specificity. These original values, however, have not been confirmed in real clinical populations; there, people with other psychiatric diagnoses can also score very highly.

Precisely for this reason, 190 must not be treated as proof. But nor may it be rendered meaningless without analysis. The RAADS-R does not measure only general social insecurity, but also lifelong social relatedness, language, sensory-motor particularities and circumscribed interests. To explain the score through ADHD and personality traits, the clinic would have to show **which subscales** were elevated and which alternative model accounts specifically for the developmental, sensory and repetitive answers.

A personality accentuation may, for example, influence interpersonal conflicts, self-image, sensitivity or social strategies. It does not, however, automatically explain lifelong sensory particularities, insistence on sameness, repetitive regulation or exceptionally stable special interests.

RBQ-2A 43

The RBQ-2A measures restricted and repetitive behaviours, routines, sensory interests and resistance to change. Precisely this score is difficult for a blanket ADHD explanation. ADHD can include hyperfocus, habits, emotional dysregulation and difficulties with switching. Classically, however, ADHD is associated more with distractibility, shifting attention and difficulty maintaining routines. A strongly elevated RRB score therefore requires differentiated examination of the concrete answers.

A narcissistic accentuation likewise does not explain repetitive behaviours and sensory-regulatory patterns as an overall complex. Here, a robust personality model would have to be presented, not merely the word "personality".

CAT-Q 167/175

This score is close to the maximum. The CAT-Q, however, is not a specific test for autism. It measures self-reported compensation, masking and assimilation. More recent research shows that camouflaging can also occur in ADHD, social anxiety and other psychological difficulties.

A high CAT-Q score cannot simply be equated with "therefore autism".

But **167 out of 175** is not merely "some masking". It describes almost continuous endorsement across a very large number of compensation and adaptation strategies. A serious alternative explanation would therefore have to answer:

> *What exactly is being compensated for, over decades, to this extreme extent?*

ADHD can explain why someone hides inattention, impulsivity or organisational difficulties. Personality-related difficulties might influence social impression management or self-presentation. But this would not yet explain why the overall response pattern specifically depicts very extensive camouflaging of social difference. The CAT-Q subscales — compensation, masking and assimilation — would have to be examined individually and connected with the biography.

EDA-QA 40/78

This score is considerably less specific. The EDA-QA measures extreme demand avoidance or a PDA-adjacent profile. The underlying study found associations not only with autistic traits but also with negative affect, antagonism, disinhibition and psychoticism-related personality dimensions.

This score could therefore indeed be more readily associated with ADHD, anxiety, autonomy problems, distress and certain personality traits. For the autism question, it is more supplementary and should by no means be weighted as strongly as the long-term biography, the RRB profile or a careful developmental history.

Aspie-Quiz 161

The Aspie-Quiz is not a clinically established diagnostic test of the same rank as standardised instruments. It emerged as a broader instrument for capturing neurodivergent or autistic traits and partly follows a different theoretical model. It can serve as an indication or exploratory supplement, but does not possess the diagnostic authority that some internet representations suggest.

A clinic could, with good reason, weight this score more weakly. It should nevertheless mention it as part of a consistent overall pattern.

A professionally legitimate position could be:

> *The self-report instruments indicate a strongly autism-related experience, but have limited specificity in psychiatric populations. Individual elevations may be partly influenced by ADHD, social distress, anxiety, camouflaging and personality factors. The responses are therefore compared at item and subscale level with developmental history, informant history, behavioural observation and functional history.*

That would be scientifically defensible.

It becomes problematic if this is reduced simply to:

> *The scores can also be explained by ADHD and personality traits.*

For "can" initially denotes only an abstract possibility. Almost every psychological characteristic can, to some extent, be co-determined by several disorders. What matters diagnostically, however, is not whether an alternative explanation is **somehow conceivable**, but whether it explains the concrete case **better and more completely**.

The Decisive Problem Is the Combined Constellation

Each individual test is open to criticism. But here, simultaneously, there were:

- two nearly maximal AQ results;
- an extremely high RAADS-R;
- a strongly elevated score for repetitive and restricted behaviours;
- an almost maximal camouflaging score;
- an elevated demand-avoidance profile;
- a very high exploratory autism score;
- diagnosed ADHD;
- an unusually stable attachment to his body of work and special interest;

- and substantial lifelong restrictions in participation.

This **convergence** is not the same as seven independent pieces of diagnostic proof, because the questionnaires partly overlap and all rely on self-report. But it creates a substantial need for explanation.

The clinic should therefore at minimum have examined:

1. Whether a common response style artificially elevated the scores.
2. Which subscales were particularly striking.
3. Which responses were clearly explainable by ADHD.
4. Which were supposed to be explainable by the later assumed personality accentuation.
5. Which responses were not explained by either model.
6. Whether autism plus ADHD explained the overall profile more parsimoniously than ADHD plus several additional interpretations.
7. How the scores fitted with the body of work, biography, informant history and functional course.

Without such an analysis, the alternative explanation is not a refutation but a **diagnostic possibility explanation**.

The clinic had not only the evaluation results, but also all the answered questions within these tests. It could therefore have examined the material much more precisely.

The explanation that autism was not present would be particularly weak if the clinic had not conducted a comprehensive personality assessment, had not diagnosed a clear personality disorder, and did not show **which concrete personality construct was supposed to explain which part of the seven profiles**. "Personality traits" must not become an unspecific residual category into which everything falls that remains after autism has been excluded.

This confronted the Humboldt assessment with a fundamental methodological problem. If the written data produced a substantially denser and broader picture of the person's life than the clinical interview, why did the interview apparently receive greater weight precisely when the two levels contradicted one another?

The interview did not simply add further information to the dataset. It transformed statements into clinically interpreted information. Between the reported life and the later report stood the diagnostician. She decided which question was asked, which answer was explored further, which statement was shortened, which context was noted, and which meaning was derived from it. The result was therefore not merely another data source alongside the questionnaires. It was already a processing of the data by a person whose selection and interpretive decisions remained largely invisible to the patient.

This raises the central question of what clinical interpretation epistemically added to the answers themselves. Was it the observation of inconsistencies? The examination of alternative explanations? The evaluation of plausibility? Placement within the biographical course? Or simply the impression the person made on the diagnosticians within a few hours?

All these functions may be necessary for diagnosis. None of them, however, automatically justifies a short clinical interview overriding a broad response pattern that is consistent across several instruments. Especially where the clinical assessment contradicts the standardised data, it would need to be made transparent what concrete additional insight the interview produced and why this insight was judged more reliable.

Such a justification would have to do more than point out that questionnaires are subjective and may be influenced by other disorders. For the interview is not free of subjectivity either. The person being questioned continues to respond from their own perspective; now, however, the subjectivity of the diagnostician is added, selecting, summarising and interpreting. The interview therefore does not remove subjectivity. It doubles it and grants one of the two perspectives institutional authority.

This necessarily had to produce alienations from the dataset.

The questionnaires at least made their structure visible. The questions were fixed, the answers were available, the scores could be traced. By contrast, the clinical interpretation remained largely hidden. The author could neither systematically inspect how individual answers had been recorded nor according to which rules the later overall assessment had been constructed from them.

According to the author's memory protocol, the diagnostician later had only one answer to this problem of the interview in the final feedback meeting:

> *"The indications of autism are not sufficient."*

As long as this weighting is not disclosed, the overall assessment remains not a verifiable integration of evidence, but a hierarchy of forms of knowledge: the person supplies extensive data about their life; the institution decides which of them count. The answers are visible. The power to devalue them remains invisible.

One can object here that the professional must decide, but research tells us that professionals are often wrong. Decisions must therefore be traceable and open to scrutiny. To assume that patients today could not do this is a highly arrogant position.

If several different instruments pointed clearly towards autism while the clinical observation produced the opposite result, it had to be explained transparently why the standardised self-reports were regarded as misleading and which alternative explanation better accounted for the totality of the scores.

The question of possible comorbidities and secondary consequences of burden also concerned the author. On 28 June, he wrote to the clinic:

> *"One more request. Since I have experienced considerable states of exhaustion and repeated decompensations for years, I would be grateful if the report — insofar as professionally indicated — could also include an assessment of possible comorbidities (burnout...) or secondary consequences of burden. Presumably you do this anyway. It would not be insignificant in the overall picture for the respective courts."*

The clinic replied the following day:

"Good day Mr Speed, thank you for the information, we will try to take this into account. Kind regards"

This email is important for what followed. It documents that, before completion of the evaluation, the author explicitly requested an assessment of burnout, exhaustion and secondary consequences of burden. In doing so, he himself introduced a differentiation into the procedure: not every form of exhaustion should prematurely be understood as a primary depressive disorder. What needed to be examined was whether it could be a consequence of decades of adaptation, overload, institutional conflict and lack of fit between person and environment.

The clinic confirmed that it would try to take this into account. The issue was therefore not merely generally known, but explicitly formed part of the still ongoing diagnostic evaluation.

At this point, several different forms of evidence were therefore available: standardised tests, clinical interviews, behavioural observation, ADOS, autobiographical information, extensive documentation through the body of work, scientific texts by the author, statements from the partner, the positive professional assessment of a long-term psychotherapeutic reference person, and the explicit request to examine burnout and secondary consequences of burden.

There was no lack of data.

What remained open was how these data would be connected with one another.

With every further conversation, the dataset grew. At the same time, the decision moved ever further away from the domain in which the author might still have recognised and corrected misunderstandings.

After completion of the informant histories, the internal team meeting was to take place. The author was informed that the decision would be made within approximately three weeks. This began a waiting phase that could appear within the organisational process as an ordinary evaluation period, but for him meant another interruption of his entire life.

The Known Prior Assessment: The X. Report

The Humboldt clinic did not have only the author's self-report before it. It also knew of an autism assessment previously conducted by Practice X. This is not to be confused with the psychotherapist friend mentioned elsewhere, who had known the author for years and had reached a differing assessment outside the diagnostic procedure.

The X. report had been produced in February 2025 and had likewise concluded that the criteria for an autism spectrum disorder were not fully met. At the same time, however, it documented an unusually high density of autism-relevant characteristics. Humboldt was therefore not assessing a patient whose autism hypothesis rested exclusively on personal conviction or an elevated screening score. It had before it a prior professional assessment that had independently described substantial components of this hypothesis.

The X. assessment did not know the later Humboldt findings. It was therefore temporally and substantively independent of the later university assessment. This increases its value as a comparative document. It was not a retrospective reaction to the Humboldt assessment, but an already existing report whose observations could have been incorporated into the later evaluation.

The X. report initially recorded an AQ score of 43 out of 50. In addition, numerous difficulties in social communication and reciprocal interaction were described. The author had reportedly stated that in groups he often monologued and did not intuitively know when it was his turn. He preferred conversations with individual people and about topics that interested him. Group dynamics bored him or were more difficult for him to grasp. Unwritten social rules caused difficulties. Small talk was experienced as uninteresting, explicit language preferred. Problems in prioritising information and a marked tendency towards detail focus were likewise documented.

The area of interests, routines and sensory processing was even clearer. X. described an extensive preoccupation with one subject during which everything else could disappear from view, as well as a special interest in social criticism and inequality. Also noted were the need for work routines, fixed places, recurring clothing and routes, fears of change, automatic sorting of objects, and tactile hand movements for calming. In addition, fragmented, strongly detail-oriented perceptual processing and sensitivities to noise, light and smells were recorded.

The report thus described relevant features in both principal diagnostic domains: social communication and interaction, as well as restricted or intense interests, routines, sameness and sensory particularities. Nevertheless, the autism diagnosis was rejected. In justification, X. referred among other things to existing empathy, emotional resonance and a fundamentally good intuitive understanding of the feelings and needs of others. The repetitive behaviour was said not to be ritualised or stereotyped to a sufficient degree. In summary, “autistic traits” were assumed, manifesting more in the personality structure, while ADHD was assigned as the confirmed principal diagnosis.

The Explicitly Communicated Doubts About the X. Report

The Humboldt clinic did not merely know that the X. report existed. The author explicitly informed the diagnosticians that he regarded this report as flawed and methodologically only of limited reliability.

According to his recollection, he explained that the assessment in a private practice had cost approximately €500 and had taken place under conditions he experienced as highly standardised mass processing. The assessment had been conducted to a substantial extent by a very young psychotherapist in training. The experienced training therapist or professionally responsible person had not been present during the actual diagnostic interviews.

These circumstances do not in themselves prove that the X. report was wrong. Neither a privately financed assessment nor the involvement of a psychotherapist in training automatically constitutes a quality defect. What matters, however, is that the author raised concrete doubts about the conduct, professional experience and supervision of the procedure. According to his memory protocol, the Humboldt diagnosticians responded by indicating that they knew the colleague concerned (meant

disparagingly) or the responsible person and would take the circumstances described into account in their own evaluation.

This created a clear diagnostic responsibility. Humboldt could not simply treat the X. report according to its negative final result. It knew that the patient explicitly disputed both its production and individual factual statements. It therefore had to distinguish between at least three levels:

- the observations documented in the report;
- their diagnostic interpretation;
- and the reliability of the underlying data collection.

Such a separation is not visible in the later Humboldt report.

The Erroneous Status of the Childhood Informant History

One particularly concrete example concerned the childhood informant history used in the X. report. It states that an aunt of the author remembered no conspicuous behaviours in childhood and had known the patient only up to the age of eight.

According to the author, this account was factually misleading or incorrect. The author lived abroad from birth until approximately the age of eight. The aunt in question therefore did not know him closely during early childhood, but only from around the age of eight onwards. Her statement that she had noticed no particularities "in childhood" could consequently not constitute a reliable informant history concerning the diagnostically especially relevant early developmental period.

The difference is substantial. A person who only regularly experiences a child from the age of eight onwards cannot provide reliable information about whether, during the first years of life, there were particularities in social communication, play, sensory processing, pragmatic language or behavioural regulation. Particularly in autism assessment, such a temporal gap must not be transformed into an apparently continuous negative childhood history.

The X. report nevertheless stated that the aunt recalled no conspicuous behaviours "in childhood", without making sufficiently clear that her own observational period did not include the early years. This could create the impression for the reader that a close reference person had observed the entire relevant developmental period and had found no abnormalities. In reality, no such observation existed for the decisive first years of life.

The author also informed Humboldt of this error. The clinic therefore knew that a central part of the negative developmental evidence in the X. report rested on an inaccurately, or at least misleadingly, represented relationship of knowledge.

This should necessarily have had consequences for the later assessment. Humboldt should have clarified:

- From what age did the aunt actually know the author?
- Which periods of his life had she personally observed?
- To what did her statement about the absence of abnormalities refer?

- Was her limited knowledge correctly documented in the X. assessment?
- What evidential value could this informant history possess for the early developmental criterion at all?

No such examination is visible in the Humboldt report. Instead, it states generally that the informant histories had not produced sufficient indications of abnormalities in the core domains.

The same structural problem is therefore repeated. A negative statement is adopted or newly produced without disclosing the reach of the underlying observation. “The aunt did not know the author during the first eight years of life” effectively becomes “No abnormalities were observed in childhood”. A gap in evidence thereby appears as negative evidence. This may have contributed to fewer questions being asked about childhood in the later interview.

The Contradictory Epistemic Status of the Prior Report

For the present investigation, it is initially not decisive whether X.’s diagnostic conclusion at the time was, overall, correct or incorrect. What matters is that the report simultaneously possessed three different characteristics:

First, it documented numerous autism-relevant features.

Second, it rejected the autism diagnosis on the basis, among other things, of justifications whose theoretical robustness was questionable, such as weighting existing empathy and emotional resonance against autism.

Third, according to the author’s account, it contained concrete methodological and factual errors, including the misleading use of a childhood informant history from a person who had not known him during early childhood at all.

The X. report was therefore neither simply a confirming negative prior report nor entirely worthless. It was contradictory comparative evidence.

Precisely its concrete description of autism-compatible features remained diagnostically relevant even if the procedure had weaknesses. Humboldt could and should have independently re-examined these details. It could have clarified whether routines, intense interests, sensory particularities, detail orientation, sensitivity to change and difficulties with implicit social communication were confirmed again. Likewise, it should have examined whether the X. assessment had collected these features incorrectly, interpreted them incompletely, or failed to connect them into an overall picture because of an overly narrow model of autism.

Instead, the Humboldt report leaves unclear what the explicitly announced consideration of the objections consisted of.

Was the X. report weighted less heavily because of its methodological weaknesses?

Were its individual statements re-examined?

Was the erroneous childhood informant history corrected?

Were the autistic features documented there confirmed or rejected?

Or did primarily the negative final result remain, while the contradictory observations and the objections to the procedure disappeared from the visible reasoning?

The report answers none of these questions.

The Contradiction Between X. and Humboldt

The X. assessment had described routines, intense interests, sameness, sensitivity to change, sensory particularities, detail orientation and difficulties with implicit social communication. The later Humboldt report, by contrast, concluded that, apart from individual social peculiarities, there had been insufficient indications in the other autistic core domains.

The difference between the two reports therefore did not consist merely in different diagnostic conclusions. The two assessments already differed in which facts they treated as present and diagnostically relevant.

Where X. listed a broad range of repetitive, sensory and interest-related characteristics, Humboldt spoke of insufficient indications in these domains. This contradiction should have been explicitly addressed within a transparent overall assessment.

An informed second assessment would at minimum have had to clarify:

Which findings from the X. assessment were confirmed?

Which were rejected on the basis of new information?

Which details were regarded as unreliable because of the methodological weaknesses of the X. procedure?

From Humboldt's perspective, were the routines, fears of change, sensory sensitivities and intense interests described there absent, insufficiently pronounced, or merely explained differently?

What significance did the demonstrably limited childhood knowledge of the aunt have?

And on what concrete evidence was the differing assessment based?

The Humboldt report neither contains a systematic comparison with the X. report nor explains why the features documented there did not contribute to a continuous autistic pattern within the final "overall assessment". Instead, it states generally that the informant histories and clinical interview had not shown sufficient abnormalities in all core domains. The already existing professional documentation is thereby not visibly refuted, but disappears from the visible architecture of justification.

An Increased Responsibility on the Part of Humboldt

Knowledge of the X. report increased the epistemic responsibility of the Humboldt clinic. This responsibility was further increased by the fact that the author had named concrete methodological and factual errors in the prior report and had been assured that these would be taken into account.

Compared with the first assessment, the university possessed an informational advantage on several levels. It knew:

- the negative final result;
- the extensive description of autism-relevant features;
- the criticism of the conditions under which the assessment had taken place;
- the limited experience of the person directly conducting the assessment;
- the absence of the training therapist;
- the procedure experienced as mass-processing and standardised;
- and the concrete error in the childhood informant history.

Humboldt could therefore have reviewed the earlier report, refined it and resolved its internal contradictions.

It should also have openly considered the extent to which this prior diagnosis might itself have influenced Humboldt as a BIAS.

More available evidence did not visibly lead to more differentiated integration. On the contrary, the later report was more concise and allowed some of the previously documented phenomena, as well as the objections to the way they had originally been collected, to disappear from its traceable reasoning.

This is also significant because the X. report itself had not developed a robust alternative model to autism. Its conclusion rested substantially on weighting existing empathy and social insight against a full autism diagnosis and assessing the described routines and repetitive features as insufficiently pronounced. Humboldt therefore could not simply rely on an already negative result. It had to examine whether the report's theoretical premises, its use of empathy as a counterargument, its assessment of repetitive characteristics and its developmental-history basis were themselves robust.

The fact that an earlier assessment had likewise not assigned an autism diagnosis did not replace independent examination of its reasoning.

Negative Transmission While Counter-Evidence Disappears

The X. report therefore entered the Humboldt procedure on at least three levels.

First, its negative final result could apparently support the later exclusion decision.

Second, the same report contained extensive documentation of precisely those features whose absence or insufficient expression the Humboldt report later asserted.

Third, Humboldt had explicitly been informed of possible methodological and factual errors in the earlier assessment and had stated that it would take them into account.

And ADHD was adopted from the X. report without being re-examined.

The document was therefore not simply a negative prior report. It was contradictory comparative evidence whose observations, interpretation and conditions of production should have been evaluated separately.

Precisely at this point, the fundamental problem of the diagnostic overall assessment becomes visible. A prior report can be read either according to its label — "no autism diagnosis" — or according to its actual content. If only the result is adopted, while the autism-compatible features documented within it, the methodological weaknesses and the factual errors are not reintegrated, an asymmetric processing of evidence emerges:

The negative conclusion remains.

The positive observational basis disappears.

The doubts concerning the quality of the data collection disappear as well.

In this way, a negative result can be transmitted across several assessments without its original justification ever being fully examined. The repetition of the result then creates the external impression of diagnostic convergence, even though what may actually be occurring is merely the onward transmission of the same unresolved negative judgement.

6. Waiting Phase and Feedback Meeting

After completion of the informant interviews and the submission of further documents, the internal evaluation began. The author was not involved in this part of the procedure. He did not know who participated in the case discussion, which documents had actually been read, how the different statements were weighted, or at which points there was disagreement within the team. He had merely been told that a decision would be made within approximately two to three weeks and that a feedback meeting would then be offered.

For the clinic, this was an ordinary evaluation phase. For the author, it meant another suspension of his life. The diagnosis was needed in ongoing court and administrative proceedings. What depended on it was not only a medical classification, but also recognition of disability, possible accommodations, participation benefits and the credibility of his previous account before authorities. While the clinic integrated the case into its internal procedures, the author was barely able to work. His thinking increasingly revolved around the impending decision.

On 2 July 2026, the day on which, according to the original announcement, the decision should approximately have been available, he wrote to the clinic:

> *"Dear Ms V., I wanted to ask whether, since the decision was apparently made today, you could also roughly inform me of the result when offering the final appointment, so that I can prepare myself better. There is considerable time pressure here."*

About an hour later, he received the following reply:

> *"Good day Mr Speed, unfortunately a decision will only be made next week and the diagnosis will only be communicated during the feedback meeting. I understand the time pressure you are under and we are also making every effort to process your case as quickly as possible. Unfortunately, these complex processes take time and we would like to give you the most accurate diagnosis possible. As soon as there is a final decision, I will send you an invitation to the feedback meeting."*

The decision was thereby postponed again. For the author, this was not merely an organisational delay. He had adjusted himself to the announced timeframe and for weeks had barely been able to do anything other than wait for the feedback. The further delay prolonged a state in which his own biography, the ongoing proceedings and his health-related future depended on an internal decision whose production remained completely invisible.

The clinic's reply was polite. Yet precisely this politeness intensified the problem for the author. It contained understanding, but no concrete information about why the decision had been delayed, which questions remained open, or whether there were differing assessments within the team. The reference to the "most accurate diagnosis" was intended to signal thoroughness, but at the same time left open what was actually still being examined.

More transparent communication could at least have reduced the burden in part. The clinic could have stated that a person involved was ill, that documents were still being reviewed, that the case conference had to be postponed, or that a particular diagnostic area required further clarification. Instead, only the institutional formula remained that complex processes required time.

For many patients, such a response may be annoying but tolerable. Under conditions of extreme diagnostic scarcity and existential dependence, it has a different effect. The person cannot simply obtain a second opinion or visit another centre a few weeks later. Every delay prolongs a state that has already lasted for years.

The author experienced another deterioration in health. The uncertainty intensified exhaustion and burnout. At the same time, fear grew that the procedure would not lead to the clarification he had expected after the conversations and the quantity of material submitted.

On 23 July 2026, the feedback meeting finally took place at the Special Outpatient Clinic for Social Interaction. As the author entered the rooms in Berlin, a heavy thunderstorm was approaching. There was thunder. He was extremely tense.

Two diagnosticians were sitting in the room. One of them was the older diagnostician who had already substantially led the first appointment. The diagnosis was not named immediately. Instead, a step-by-step explanation of the procedure began. This form alone already made the author suspect that the autism hypothesis would be rejected.

The following account is based, insofar as no written documents are quoted, on a memory protocol produced immediately after the conversation. This protocol records not only the results communicated, but also the course of the dispute, the notes shown and the responses to objections.

At the beginning, individual notes and areas of evaluation were shown to the author on a monitor. According to his recollection, this was done by scrolling quickly. The author had to force the diagnostician to stop so that individual points could be addressed concretely. The author wanted to

know exactly where the problem lay. It was repeatedly explained that the decisive factor was not individual aspects, but the overall assessment.

The first substantive block concerned restricted and repetitive behaviours and interests. The diagnosticians explained that neither a sufficient special interest nor sufficient repetitive behavioural patterns could be established.

For the author, this was the first fundamental rupture in the conversation. Precisely this domain appeared to him the least doubtful in light of his biography. As already described, for almost three decades he had lived largely outside regular employment while at the same time working daily on a coherent artistic and theoretical body of work. This body of work encompassed books, films and a large number of scientific texts. Despite changing forms and topics, it repeatedly revolved around the same structural problems. When he was unable to work on it, he entered crises and severe states of exhaustion, according to his own account.

> *(Memory protocol): "I am stunned. I do not understand what is going on here. I have repeatedly explained to you that I have been unemployed for 27 years because I work 40 hours a week on a body of work. Unpaid."*

These facts had not only been reported orally. They had been documented through the publicly accessible body of work, the books submitted, the papers and the scientific statement. Nevertheless, the clinic's central conclusion was that no diagnostically relevant special interest was present.

In research, *circumscribed interests* are usually described as:

> **intense, strongly focused and often idiosyncratic interests that bind an unusual amount of time, attention and motivation and are difficult to interrupt or shift away from.**

The author, who could now read the sparse and keyword-like notes of the colleague on the monitor, found in them a naïve lack of knowledge and misunderstanding of almost all of his statements. The diagnostician had apparently not understood that he was not speaking here about an ordinary occupational process.

According to the memory protocol, neither diagnostician engaged substantively with this objection. The author experienced this silence as a refusal of correction. Because a comparable pattern recurred with several objections, he developed the impression that non-response served a methodological function within the conversation. Whether it was consciously used as such cannot be established.

That alone immediately produced the gaslighting experience again, as a result of which the author became visibly emotional, meaning angry, and therefore somewhat louder.

The older diagnostician then said (memory protocol) that their autistic patients did not behave like this. This not only described the author's behaviour but simultaneously disclosed an implicit comparison model: autistic people apparently appeared within it as more compliant, withdrawn, less confrontational, possibly less direct or less visibly angry.

The opposite image would presumably have been represented by Greta Thunberg with her famous *"How dare you?"*

AuDHD likewise contradicted these classical clinical conceptions of autism quite strongly in its outward presentation.

The author could have lived with a discourse about this, but not with silence in the face of facts presented. The objection raised was neither substantively refuted nor recognisably clarified in the conversation. It remained unanswered. For the author, this meant that a possible error in the finding was not examined.

The older diagnostician repeatedly smiled in a way the author perceived as superior and defensive. For him, the impression arose that his insistence itself was already being read as part of a different psychological picture.

For a diagnostic evaluation of the special interest, the following would have been particularly relevant:

- extraordinary **intensity and temporal dominance**;
- long **duration and recurrence**;
- difficulty interrupting or shifting attention;
- structuring effect on everyday life, relationships and occupation;
- emotional or regulatory significance;
- possible substantial costs when other areas of life recede;
- not necessarily an unusual topic, but an unusual relationship to the object.

The author lived almost exclusively for the body of work. An autistic special interest is not determined solely by its subject matter. What is decisive is the form of attachment: an unusually intense, enduring, repetitive and life-organising focus that demands substantial time and attention, can displace other activities, and frequently fulfils a central regulatory, motivational or identity-forming function.

According to the author's biographical self-report, his ability to work was so strongly bound to the body of work that there was regularly hardly any energy, coordination or scope for action left for other activities.

At this point, it became clearly apparent for the first time that the conflict concerned not merely differing interpretations of individual symptoms. There were different realities regarding what could count as knowledge within the procedure at all.

As the conversation continued, this was to condense into four realities separated from one another.

The first was the **private reality of the diagnostician**. According to the memory protocol, the older diagnostician repeatedly explained in substance that privately she would assess certain questions differently, but within the procedure she had to adhere to the applicable rules. She thereby distinguished between her personal professional assessment and the statement she was able to represent within the institutional framework. She said (memory protocol) that she wanted to keep her job and therefore did it this way, although she also thought that many things were open to discussion.

The second was the **clinical-institutional reality of the procedure**. Here, the prescribed instruments, coding, established criteria and internal overall assessment applied. This reality had decision-making force. It determined what would appear in the report, which diagnosis counted as officially recognised and which statement would later carry weight before courts and authorities.

The third was the **reality of scientific autism research**. Within it, masking, the limits of standardised observational procedures, the problems of late-diagnosed adults and the possibility of strongly compensated profiles had long been subjects of intensive discussion. The author repeatedly referred to this research. Within the concrete procedure, however, it remained unclear what effect this body of knowledge was permitted to have when the formal clinical requirements led to a different outcome.

The fourth was the **life reality of the author**. Within this reality, the diagnostic statements had to be measured against more than five decades of biography, almost three decades of work production, exclusion from employment, recurring communication problems, overload and the structure of his daily work. For him, the clinic's explanation could not be reconciled with this reality.

These four realities stood next to one another in the feedback meeting without converging into a shared understanding.

There was the clinic that had been sued. A setting reminiscent of gaslighting. The epistemic devaluation of the author and independent autism researcher. And the decision not to accept corrections because this was not provided for. Regardless of the consequences this would have for the author's life.

The diagnostician could privately express doubts or differing views while simultaneously representing an opposite finding institutionally. The institution could refer to clinical requirements even if, according to the author, these did not correspond to the current state of research. ICD-10 was used instead of 11, even though it was 2026. Research could describe methodological limitations without this resulting in any limitation of the diagnostic decision. The author could present his biography and the available evidence without this recognisably changing the judgement that had already emerged.

Precisely the repeated remark that privately the diagnostician viewed certain things differently is therefore central. It shows that the problem did not necessarily lie in complete lack of knowledge. At least according to the author's recollection, within the person herself there was a difference between what she as a professional might possibly have considered plausible and what she had to represent as the result within the institutional procedure.

This created a difficult ethical question: what responsibility does a diagnostician bear when her personal or scientific assessment differs from the result produced by the clinical requirements?

We do not know to what extent these differed or whether they really did. But it was suggested.

This immediately led to a political debate in which the author accused the diagnostician of cowardice because, in his view, she placed keeping her job above the scientific facts.

Clinical diagnosis must not depend on spontaneous private convictions. Precisely for this reason, standardised criteria exist. If, however, the professional simultaneously indicates that these rules may lead to an insufficient result in the specific case, she cannot simply retreat to their application. At the very least, the scope of the finding would then have to be limited and the existing uncertainty transparently documented.

It would have to appear in the report. Especially when there was a political relationship of tension between the clinic and the author that obviously also affected the diagnosticians. Because they could not refrain from asking about the reasons for the lawsuit. In doing so, they could not maintain neutrality. In film one would say that they broke the fourth wall. They looked directly into the camera and thereby destroyed the illusion of the story.

The private assessment therefore remained without consequence. The current state of research on special interests remained without consequence. The author's objections remained without consequence.

The official result thus did not necessarily emerge from the reality that one of the persons involved considered the most complete. It emerged from the reality that was institutionally codable and billable to the health insurer.

It becomes apparent that the diagnosticians ultimately behaved according to the rules of capitalism, according to the customs of salaried employees, while the author risked his life in order, from his perspective, to provide important data to research.

After the rejection of a special interest, the conversation moved to social difficulties. In this domain too, according to the clinic's account, no sufficient abnormalities had been identified. The author again pointed out that he was 53 years old, gifted and had been accustomed for decades to consciously analysing and controlling social interaction. He had learned psychotherapy, worked with different roles as an artist and engaged scientifically with communication and masking. The fact that he could conduct a conversation with diagnosticians for a few hours therefore did not, from his perspective, explain why over decades he had repeatedly been misunderstood and socially excluded in occupational, institutional and private contexts.

His life was full of communicative misunderstandings.

He pressed the diagnostician to explain what exactly he was supposed not to be able to do. The image drawn by the diagnostician appeared to be a caricature of an autistic person who was stupid and incapable of learning. At any rate, less intelligent than she herself. Clumsy in language and incapable of looking someone directly in the eye.

The author responded (memory protocol):

> *"It is clear to me that you, as the Humboldt clinic, have a problem because you massively overvalue social deficits compared with the thinking and experience of autistic people. That is generally known. But that you think about autistic people in this way — this image of autism is simply wrong. How stupid do you think we are? How do you arrive at the idea that someone could not learn this over decades?"*

He pointed extensively to the fact that this judgement did not represent his life full of social misunderstandings and exclusions. It had nothing to do with reality. The clinic was constructing a clownish fantasy of an autistic person who was like a robot.

A diagnostic approach that strongly weighs successful situational reciprocity against autism enters into an obvious validity conflict with the real diversity of recognised and openly public autistic people.

(Greta Thunberg, Julian Assange, Elon Musk…) In his manner of appearing, for example, the author resembled the German biologist and presumed autistic person Mark Benecke, with whom he had appeared at a public event years earlier. Anyone who understands autistic people only as wooden therefore risks measuring not autism, but above all its lack of compensation and its immediate social visibility.

The author often appears communicative, humorous and strongly reciprocal in public and professionally bounded situations. This manner resembles the performative style of highly specialised public science communicators. It does not, however, refute a neurodivergent or autistic underlying structure, but can itself be an expression of social performance that has been developed over decades, is bound to specific topics and is highly controlled. The decisive question would therefore not merely be whether reciprocity is observable, but how it is produced, under what conditions it remains available and what costs its maintenance entails.

Whenever the author disputed individual assessments, the diagnosticians repeatedly referred to the overall picture. In his impression, however, this overall picture could not be explained independently of precisely those individual assumptions he disputed. The more individual findings were questioned, the more strongly the overall assessment was invoked as the final justification.

The overall assessment thereby no longer functioned merely as a necessary integration of different data. It became a level that escaped direct examination. Individual observations could be erroneous or misleading; the overall judgement was nevertheless supposed to remain in place. When asked how this overall judgement was still constituted once the disputed assumptions were removed, the author received no concrete answer.

The diagnostician was not able to answer this, or did not want to.

Apart from subjective gut feeling, if one provocatively wishes to reduce diagnostic competence to that, there were now hardly any concrete facts left that contradicted autism. The author was able to judge this at least to a considerable extent because he was not without professional knowledge in this field. Even without such knowledge, common sense already took the criticism quite far.

The assessment of the special interest and repetitive behaviour had obviously been demonstrated to be erroneous. There was no response from the clinic to this whatsoever. The author referred to high masking scores that could conceal the social deficits. This had already been comprehensively substantiated scientifically by the author in the paper submitted in advance. ADOS was explained as completely unsuitable for the profile. Humboldt later itself stated this in the report. Everything that therefore remained scientifically robust and spoke against autism was the in-depth interview, which was rather thin, and the reference to an “overall picture” that now appeared ominous. What spoke for autism were massively elevated screening scores, the statement of a psychotherapist who had known the author for more than ten years, and 3,000–4,000 pages of publicly accessible publications by the author in which his life had been comprehensively documented and at times analysed in the context of autism.

Over the course of the conversation, the older diagnostician increasingly moved into a defensive posture. She repeatedly pointed out that she did not have much time left and would soon have to leave for another appointment. They had been sitting together for only 30 minutes.

This repeated the temporal structure of the first diagnostic day: the final meeting, in which an existentially significant and strongly disputed result was supposed to be explained, was once again under pressure from a subsequent appointment.

This was particularly problematic because the feedback meeting represented the first real opportunity to examine the picture produced by the clinic. The assessment had collected and internally evaluated data over weeks. Six weeks passed from the assessment to the team meeting. It can be assumed that data were lost through the temporal distance alone.

The intended timeframe was hardly suitable for serious correction.

How could one correct notes whose details and contextualisation the diagnosticians themselves could hardly have remembered after more than six weeks? At any rate not with the precision required for this.

In connection with the diagnostic foundations, the author asked whether diagnosis had been conducted according to ICD-11. The diagnostician explained that the clinic worked according to ICD-10. A longer dispute then arose about the difference between clinical diagnosis and the current state of scientific knowledge.

The author argued that a strongly masking, gifted adult with an already existing ADHD diagnosis could be particularly easily overlooked and discriminated against within an older diagnostic framework. He pointed out that modern autism research takes masking, compensation and heterogeneous presentations much more strongly into account.

The diagnostician explained that clinical diagnosis and scientific knowledge were not identical. Repeatedly, she had also indicated that privately she might see some points differently, but within the procedure she had to adhere to the existing requirements.

This statement brought the four realities into their full sharpness.

The report turned this chaos into an official document. That was fatal.

One should remember: this concerned a human life, a decision with massive consequences.

For the author, this meant that the clinic produced an unequivocal non-diagnosis in relation to him, even though during the conversation it simultaneously became apparent that the foundations of this unequivocal conclusion were themselves disputed.

The diagnosticians could retreat to the claim that the finding was merely a clinical assessment. For courts, disability authorities, health insurers and other public bodies, however, it was far more than that. There, the letterhead of a university specialist clinic would be treated precisely as a sign of scientific authority. The institutional modesty inside the room and the institutional power outside it therefore stood in a considerable mismatch.

The clinic could say: It is only our assessment.

The state would turn this into: There is no autism.

Precisely therein lay, for the author, the violence of the situation. The doubts remained private, the limitations remained scientific footnotes, but the negative judgement became publicly effective.

The feedback meeting had not yet ended at this point. After the discussion of special interest, social communication, overall assessment and diagnostic foundations, the individual test results, the informant history and the alternative diagnostic classifications followed. But already now, the basic structure of the conflict had become visible: the participants were no longer merely speaking about different evaluations of the same data. They were moving within four realities, only one of which possessed the power to become official.

Of course, this investigation cannot reproduce everything that happened during these hours one-to-one. It is conceivable that the author remembers certain points incorrectly or weights them differently. The problem is that this cannot be compensated for when a clinic categorically refuses corrections and categorically terminates dialogue about them.

For this investigation, it is fruitful to document this at all and place it up for discussion. The author does not issue a final judgement here, but provides data that have strengths and weaknesses.

It should be explicitly pointed out here that the content of the findings report is reproduced in this publication completely with regard to its essential data and assessments, but that its basis was a four-page A4 summary of the assessment results. Not all documents were therefore accessible to the author. He was able to take a brief look at the diagnosticians' notes, but could not read them in full. What matters here is that, upon request, no further information was provided, meaning no further access was made possible.

The clinic shielded itself.

7. Comorbidities and Secondary Consequences of Burden

After Humboldt University had rejected autism in the overall assessment, the feedback meeting shifted towards other possible explanations for the author's health and social difficulties. In addition to the pre-existing ADHD diagnosis, the written report recorded dysthymia and an accentuation of narcissistic personality traits. In addition, the Liebowitz scale produced a score that the clinic assigned to the range of generalised social phobia.

> *"Liebowitz Social Anxiety Scale (LSAS): The LSAS measures the extent of social anxiety in the form of fear and avoidance across different social situations, as can typically occur in the context of social phobia. Total scores range from 0 to 144 points, with higher scores indicating a greater degree of social anxiety. Total scores of 0–29 are considered unremarkable, scores of 30–59 indicate a (non-generalised) social phobia, and scores of 60 or above are interpreted as indicating generalised social phobia. You achieved a total score of 66 points, consisting of fear in social situations (34) and avoidance of social situations (32). Beck Depression Inventory (BDI): The BDI measures the extent of depressive symptomatology. Possible total scores range from 0 to 63 points, with higher scores indicating greater severity of depressive symptoms. Scores of 0–8 are considered unremarkable, 9–*

13 mild, 14–19 slight, 20–28 moderate and 29–63 severe depressive symptomatology. You achieved a total score of 30 points."

The author immediately replied that all of this was wrong. He did not have social phobia. He could immediately walk onto a stage in front of 1,000 people and sing a completely improvised song. Social interactions exhausted him and he therefore had an aversion to them, but he had no fear of them whatsoever.

Again, there was no response from the diagnosticians.

Nor was he depressed, as had been established, see above in the text, at the appointment at the beginning of the assessment. This could be one aspect, but depression did not explain the overall picture.

These findings were not incidental. Within the overall assessment, they took on a double function. On the one hand, they were intended to name existing suffering. On the other hand, they were used to explain features that remained in need of explanation after autism had been excluded. The report later stated explicitly:

"In our assessment, the abnormalities in the AQ and SRS questionnaires can most plausibly be explained by insecurities in the context of narcissistic personality traits and ADHD."

But "most plausibly" is not a fact. This already made no sense because these measured values did not say precisely that, as will be discussed below. This would have had to be examined in detail instead of referring in general terms to a mere possibility in order thereby to marginalise inconsistencies in the overall assessment.

Because this was not concretely justified on the basis of the actual answers within these questionnaires, which would have shown that neither ADHD nor personality disorders explained the picture, it remained an unsupported assertion that was nevertheless treated as though it refuted autism.

From the report:

"There are individual abnormalities, particularly in the area of social interaction, but not in the other core areas. The difficulties you describe are nevertheless readily understandable and can be understood in connection with other psychological burdens or personality traits."

Almost anything "can" be understood as a personality trait. One would be surprised how easy that can be. One considers one's own achievement good. An indication of narcissism. One questions one's tax return. An indication of paranoid personality.

There are reasons why diagnoses are subjected to specific examination. So that they do not become projections serving a particular purpose, for example concealing or producing alternative readings.

Alternative explanations had to meet a demanding standard. They had to explain not merely individual symptoms. They had to explain why, for decades, the author failed within ordinary employment and social structures while at the same time working with extraordinary endurance on a single coherent body of work; why social communication was situationally possible but repeatedly fragile over the long

term; why repeated decompensations occurred; and why several autism-related screening procedures independently produced clearly elevated results.

An alternative is diagnostically superior only if it explains more than the rejected hypothesis. It is not enough to distribute individual concepts across individual symptoms.

Thus, although there was an overall picture within the assessment that appeared coherent to the diagnosticians, there was no testing of this against the overall picture of the life and suffering of the person concerned. For there, the author pointed to massive inconsistencies.

There is a difference between saying that high autism scores could also be explainable through personality disorders and actually examining whether there are so many indications of this in the person's real life that it explains the person's life and suffering better. The alternatives already lacked the long-term effect over 30 years and more, whereas symptoms readable as autistic were present across that period.

Social Anxiety or Social Overload

In the written report, a total score of 66 was given for the Liebowitz Social Anxiety Scale, composed of 34 points in the domain of fear and 32 points in the domain of avoidance. According to the interpretation explained in the report, this score fell within the range of generalised social phobia.

The score was therefore elevated. Just as elevated as the other autism-related scores. What was disputed, however, was its meaning.

The author did not dispute that he often avoided social situations. Nor did he dispute that social constellations could involve substantial tension. He did, however, reject the interpretation that this avoidance was primarily caused by a phobic fear of people or social evaluation.

For him, the problem lay elsewhere. Crowds of people, unclear expectations, rapid changes, contradictory signals and social unpredictability were exhausting. He did not necessarily avoid such situations because he had an irrational fear of them, but because he knew their real costs. Social withdrawal could therefore be a response to overload, stimulus density, recurring misunderstandings and the experience of regularly being misread or excluded in social contexts.

In addition, it would be rather unusual for someone with social phobia to conduct a public legal case against a major Berlin institution, including press releases. Such exposure of one's own person in public would make social phobia highly in need of explanation. There are, of course, rock stars with social phobia, but the author had not really reported this kind of fear. At the latest after his objection, the matter should have been explored further.

This distinction is diagnostically central. Two people can avoid the same situation and obtain the same questionnaire score even though the underlying mechanisms are different. One person fears humiliation or negative evaluation. Another expects sensory, communicative and cognitive overload. A third avoids the situation because long experience has taught them that they will require several days afterwards to recover.

The questionnaire initially measures fear and avoidance. It does not automatically determine why these occur. It could even have been due to a careless error while completing the questionnaire. Perhaps the author had clicked in the wrong place with the mouse, or, out of concern that something might be overlooked, had tended to exaggerate.

The suspicion arose that the diagnosticians had simply forgotten what exactly had been diagnosed more than six weeks earlier, and the notes, as shown to the author on the monitor, consisted only of keywords.

This therefore repeated the problem already visible with the autism questionnaires. The score required interpretation. But precisely this interpretation could not follow solely from the height of the score. It would have had to be clarified what the fear was directed towards, which thoughts, bodily reactions and expectations existed in the respective situations, and whether the avoidance was explained by anxiety, overload, stimulus protection, negative learning experience or a combination of these factors.

But the time available within the setting was insufficient for this. The diagnosticians rushed through the procedure. The constant clattering of their keyboards was also massively distracting.

What scientifically robust content did these differential diagnoses even possess in themselves if they took place merely as a by-product of an autism assessment? What right was there to formulate them as findings when ultimately they could only be suspicions?

Well, they were needed precisely as what they were presented as: robust alternative explanations for rejecting an autism diagnosis. The rejection had somehow to be explained. The emphasis is on "somehow".

The diagnostic question should therefore not have been whether the author avoided social situations. That was undisputed. It should have been:

> *What exactly was being avoided, why was it being avoided, and what function did the avoidance serve?*

Without this clarification, there was a danger that autistic or neurodivergent self-protection would be translated into the vocabulary of an anxiety disorder.

As formulated at the beginning, this investigation is not so much concerned with determining whether social phobia or autism was present, but with the question of whether this constituted a serious diagnostic procedure at all. Can one speak here of a scientifically robust assessment? Yes or no? And what are the consequences for autism assessment itself, which is conducted in precisely this way at many clinics?

Dysthymia or Chronic Exhaustion

The problem became even clearer with the diagnosis of dysthymia.

The report cited a BDI score of 30 and explained that the author had met the criteria for dysthymia in the structured clinical interviews. According to the clinic, the court disputes contributed to maintaining the depressive disorder "in the sense of chronic exhaustion".

This formulation already conflated two different phenomena: depressive mood and chronic exhaustion. Exhaustion can form part of depression. But it can equally result from persistent overload, sleep deprivation, chronic stress, ADHD, autistic burnout, poverty, physical illness or a combination of these factors.

The author had not first raised this distinction after receiving the report. Already during the first assessment appointment, according to his documentation, depression and exhaustion had been discussed in detail as distinct phenomena. The diagnostician had initially expressed the impression that he did not appear to have depression. The author explained that he was not prone to depressive emptiness. He was neither hopeless nor resigned. Even in severe crises, his interest in his work remained. The greater the external crisis became, the more strongly his attention could narrow onto the body of work. There he continued to find energy, meaning and cognitive activity.

The question also arises how someone with such severe depression could summon the energy to litigate all the way to the Federal Constitutional Court. This does not completely exclude depression, but it does give one pause.

On 28 June 2026, he had additionally asked the clinic in writing to classify possible comorbidities, burnout and secondary consequences of burden explicitly in the report. The clinic replied that it would try to take this into account.

The differential question was therefore clearly formulated before the procedure was completed:

> *Was this a primary chronic depressive disorder, or was the exhaustion a secondary consequence of long-term neurodivergent overload, institutional conflict, masking and lack of fit with the environment?*

The later report did not answer this question in a traceable manner. It named dysthymia and incorporated the chronic exhaustion into its explanation. Yet precisely what, in the author's view, should have been the subject of differential diagnosis was thereby treated as a consequence of depression.

The BDI score of 30 documented substantial current distress. Here too, however, not every affirmative answer was diagnostically unambiguous. Increased need for sleep, exhaustion, decline in performance, physical burden and the experience of having been trapped for years in court and administrative proceedings could produce high depression scores without all these symptoms necessarily arising from a primarily depressive process.

One could, of course, also be both depressed and autistic.

Particularly important was the temporal and functional structure. The author did not report a general dissolution of his interests, continuous inner emptiness or loss of the capacity to experience joy and meaning. His capacity for action was selective. It collapsed in externally controlled, administrative and social contexts, while within his own body of work it partly remained intact or even intensified.

The author had formulated:

> *"My actions are extremely driven by meaning. As long as something makes sense, I have energy."*

The lack of energy at the diagnostic appointment was predominantly connected with the fact that the lengthy procedure was driving him into exhaustion and loss of meaning.

Depression can also take a selective course. But precisely then it must be explained why the pattern fits dysthymia better than chronic neurodivergent overload. The report did not show this weighing. No differentiation was made.

When asked, the diagnostician could not explain how she had arrived at the diagnosis. She scrolled nervously through notes because she no longer remembered. In this way, nothing could be reviewed anymore.

Instead, a peculiar diagnostic movement arose: the massive exhaustion was initially coded as part of dysthymia, while the possibility of autistic burnout practically disappeared from the picture once autism had been excluded.

Or put differently: in order to exclude autism, the symptoms of autistic burnout had somehow to be explained differently. This meant that the comorbidity assessment logically depended on the preceding autism decision. Once autism had been rejected, autistic burnout could hardly remain available as an explanation. The prior decision therefore determined which forms of exhaustion subsequently remained thinkable at all.

Here too, the author objected and explained the distinction, but was ignored. Contradictions were not addressed.

Constructing social circumstances as the logical basis of a depression could indicate a bias rooted in classism. Poor people simply all have depression. Makes sense. File closed.

The Problem of Secondary Consequences of Burden

In the author's case, years of institutional and existential burdens were present. These included poverty, lack of diagnostic recognition, repeated conflicts with authorities and courts, blocked support, fear for his own existence, and the permanent demand to prove his own life reality again and again to institutions.

That such conditions can produce or intensify depressive symptoms is unsurprising. The decisive question, however, is what position these symptoms occupy within the case formulation.

Are they the primary explanation for the entire course of life?

Or are they the result of a course of life whose underlying structure remained unresolved?

The report recognised the court disputes as a maintaining burden factor. It did not, however, visibly investigate why these disputes had arisen over years, why the author repeatedly escalated in institutional contexts, and why the same constellation of detail depth, persistence, rule orientation, overload and communication conflicts recurred across different areas.

The court proceedings thereby appeared as a cause of psychological burden. But they were simultaneously material of a possible neurodivergent life structure. It was completely disregarded that

the author, as was visible in his body of work, criticised authorities with autistic precision and could not ignore even the smallest errors when they led to massive injustices. He could also have been recognisable as a kind of Greta Thunberg (autistic) of welfare-state criticism. The diagnostician even held in her hands the author's book titled: *Speeds Arbeit: Eine autistische Intervention in den Arbeitsbegriff – In Zeiten von KI und Robotik (Artistic Research – Neurodivergente Forschung).*

The author did not become involved in these proceedings by chance. He pursued them with extraordinary intensity because he could not leave contradictions, injustices and structural errors unaddressed and because his existence depended on the outcomes.

A purely depressive classification therefore once again risked naming the consequences while omitting the underlying architecture.

Comorbidity or Substitute Diagnosis

Comorbidities do not contradict an autism diagnosis. ADHD, anxiety disorders, depressive illnesses and exhaustion can coexist with autism. In late-diagnosed adults, secondary psychological problems may even be expected when no suitable explanation, support or environmental adaptation has been available for decades.

Precisely for this reason, it was methodologically problematic to use the additional findings primarily as alternatives. The question should not merely have been:

> *Can dysthymia, social anxiety, ADHD or personality traits explain individual abnormalities?*

It should also have been:

> *Can these burdens themselves be consequences of a neurodivergent structure that remained unrecognised for decades?*

In the report, the ADHD diagnosis was adopted as clinically plausible without being re-examined. Dysthymia and narcissistic personality traits were newly established. These three domains were then supposed jointly to explain why the autism questionnaires were markedly elevated.

But this was precisely what they could not do. When asked, neither diagnostician was able to explain how they had arrived at this assessment, but again referred to the ominous overall assessment.

No coherent alternative model therefore emerged. ADHD explained parts of attention, impulsivity and organisation. Dysthymia was supposed to explain exhaustion and distress. Social anxiety was supposed to account for avoidance of social situations. Narcissistic personality traits were apparently supposed to make further insecurities and self-reference plausible.

Their shortened version of the biography was distributed across several diagnostic categories.

But distribution is not the same as explanation.

A robust model would have had to show how these different diagnoses jointly produced the structure that remained constant over decades: the extreme attachment to the body of work, dependence on self-

determined work, the discrepancy between social ability and functioning, recurring institutional collisions, masking scores, repetitive interests and the long-term costs of adaptation.

Precisely this remained open.

If only one of these alternatives failed, all of them failed — and in the end, all of them failed.

The diagnosticians already had before them, prior to the assessment, the scientific explanation regarding the need for explanation when rejecting an autism hypothesis (Appendix 1). This demonstrated the substantial requirement for an extensive alternative justification. This also had legal consequences. It was introduced into the assessment as evidence. The clinic did not address it with a single word, meaning it apparently did not examine the resulting gaps in its report. Legally, a massive error.

The Reversal of the Burden of Proof

The comorbidity assessment thereby acquired a peculiar function. The autism hypothesis had to prove its entire biographical reach. The alternative diagnoses, by contrast, apparently needed only to touch individual symptoms in order to be admitted as explanations.

High autism-related scores were relativised as unspecific. A high BDI score, by contrast, could directly support a depressive diagnosis. Avoidance of social situations could be read as social anxiety without fully clarifying the mechanism of avoidance. The long-term attachment to the body of work had to satisfy strict criteria for a special interest; individual answers concerning recognition, envy or self-worth could later (see below in the text) be used to justify narcissistic personality traits, even though the clinic itself stated that it had not diagnosed narcissism. It merely suggested it. It placed it into the room and remained silent about it.

Different thresholds of explanatory burden applied.

For autism, a continuous, early-beginning and sufficiently unambiguous structure across all core domains was demanded. For the alternatives, current questionnaire scores, a few interview statements and clinical interpretation were partly sufficient.

Precisely because the case was complex, diagnostic caution should have applied in both directions. Uncertainty could not be allowed only to weaken the autism hypothesis. It likewise had to limit confidence in the alternative explanations.

No Help Through Conceptual Displacement

The author had explicitly asked the clinic for an assessment of secondary consequences of burden. He wanted to know why he was exhausted, why he repeatedly decompensated and what form of treatment or relief might follow from this.

The report provided a diagnosis of dysthymia and recommended outpatient behavioural therapy.

A treatable category had therefore been named. It remained unclear, however, what concrete case formulation underlay this recommendation. Was the therapy supposed to alter depressive thought patterns? Reduce social anxieties? Address self-worth and narcissistic insecurities? Structure the consequences of ADHD? Or compensate for decades of overload through institutional and social mismatch?

The recommendation remained general because the alternative model remained general.

The comorbidities therefore did not necessarily explain more. Above all, they made it possible to transfer the remaining suffering, after autism had been excluded, into already available clinical categories.

Precisely here lies the decisive difference between naming and explaining.

The author did not deny being exhausted, distressed and in part showing depressive symptoms. He denied that these concepts sufficiently explained the structure of his life. They named states that were to be expected after decades of failure and overload. But they did not explain why this failure and overload had arisen in precisely this form.

The comorbidity assessment therefore answered the question:

> *Which symptoms are currently visible?*

It did not answer the question that was decisive for the author:

> *Which structure produced these symptoms over decades?*

The accentuation of narcissistic personality traits acquired an even more far-reaching function within this explanatory model. It did not merely describe an additional domain of burden, but threatened to pathologise the author's insistence on his own evidence, his artistic self-use and his criticism of the clinic itself. This requires separate examination.

8. The Narcissistic Personality Accentuation

The most problematic alternative classification in the diagnostic report was the attribution of a narcissistic personality accentuation. (Z73G)

The written report stated:

> *"In the area of personality disorders, you have a narcissistic personality accentuation (Z73.1). A narcissistic person is characterised, among other things, by a grandiose sense of their own importance, deficits in empathic capacity, feelings of envy towards others or the belief that others envy them, as well as arrogant or haughty behaviours and attitudes."*

This wording was initially contradictory. On the one hand, the clinic did not diagnose a fully developed narcissistic personality disorder, but rather a personality accentuation. On the other hand, this was immediately followed by a general description of "a narcissistic person" listing central characteristics of

a pathological narcissistic structure. For external readers, authorities and courts, this could easily create the impression that a clinically substantiated narcissistic personality problem had been established.

This bordered on defamation.

The distinction between personality accentuation and personality disorder is, however, substantial. An accentuation initially refers to more pronounced traits that do not necessarily reach the severity, rigidity, comprehensive impairment and biographical stability of a personality disorder. It can neither be equated with a full narcissistic personality disorder nor used without further justification as a comprehensive alternative explanation for a functional profile spanning decades.

In the present report, however, it remained unclear which concrete observations had been assigned to which narcissistic characteristics, how strongly these were supposed to be expressed, in which areas of life they appeared, and why the clinic derived a diagnostically relevant accentuation from them.

A term was assigned, but no traceable case formulation was provided.

The clinic could have resolved this through a simple differentiation, which it did not make. Is the drive motivated by the pursuit of success, or, as in the author's case, by the intrinsic motivation to investigate patterns in systems? Does failure lead to breakdowns, or is it, as with the author, that problems arise when orders are inconsistent, falsehoods are not corrected, or injustice occurs? That is an autistic researcher profile, not narcissism.

Instead of examining this, the diagnostician apparently simply inferred an intention towards elite success from elite artistic and research productivity. But someone driven by success and admiration does not work for 27 years without any recognition while devoting themselves entirely to substantive questions. A drive for admiration should also long since have led to a massive breakdown here. One does not write 11 books, 19 monographs and 100 papers without any external recognition if narcissism is the driving force. There must already be a completely different source of motivation. And this had been comprehensively presented. The author's body of work was extremely monotropic, showed *veridical mapping*, as well as a mode of writing and thinking often read as autistic and described in research as hyper-systemizing.

Few Questions, Far-Reaching Conclusions

According to the author's memory protocol, the corresponding assessment was based substantially on a few brief questions during the first diagnostic appointment.

The diagnostician asked approximately:

> *"If I tell you that you have written a good book, do you like that?"*

The author answered yes. He wanted to explain his answer further along the usual qualification of modesty, but according to his recollection was already confronted with another question:

> *"Do you envy anyone?"*

He replied that he envied some people for having a professorship, but in an ordinary and by no means obsessive sense. When asked whether other people envied him, according to his documentation he referred to the occasional perception that some people might envy him the freedom that arose from the fact that, as an impoverished author without institutional affiliation, he did not have to take academic career planning into account.

None of these answers in itself demonstrates a narcissistic structure. Most people would answer similarly. One also does not want to appear as though one were not vain at all.

That an author finds recognition for a book pleasant is initially to be expected. Wanting recognition for work performed is not identical with an insatiable need for admiration. Likewise, ordinary envy is not a sufficient sign of a personality problem. People can envy others for occupational security, status, income, health or institutional opportunities without this implying a pathological personality organisation.

What would have mattered was not whether such feelings occurred at all. Their intensity, frequency, rigidity, biographical significance and effect on relationships and behaviour would have had to be examined.

This deeper examination is not visible in the report. The diagnosticians were also unable or unwilling to explain it when asked.

Instead, a series of ordinarily human answers appears directly alongside a general list of narcissistic characteristics. This created the danger that the diagnostic category retrospectively acquired more significance than the underlying statements could support.

For the clinic created the impression that this would alternatively explain the autism symptoms. But which ones exactly?

The Pathologisation of One's Own Work

The author's self-presentation within his body of work appears to have played a particular role.

The clinic had three of the author's books. His photograph appeared on the respective covers, which is initially not unusual for authors. In addition, he had submitted the feature film *Transferprotokoll*, in which he himself played a leading role. According to his intention, these materials were meant to document an artistic, theoretical and biographical mode of working that had remained stable over decades and made certain autistic profiles interpretable. They were apparently read at least partly as an expression of strong preoccupation with his own person.

This created a fundamental category problem.

In autobiographical art, autofiction, performance, film and Artistic Research, one's own person can be used as material, figure, experimental arrangement or methodological access point. The author's appearance in his own work therefore does not automatically mean that its primary subject is admiration of his own person. The self can be used as a sensor, catalyst and documentary carrier of social processes.

Autistic people can also often have difficulty judging what degree of self-presentation is socially appropriate.

Precisely the use of his own person as a catalyst of processes was, according to the author's account, part of his method. He conducted conflicts with institutions not only as a private person, but documented them through an artistic persona as provoked empiricism. His own position was deployed in an artistic figure in order, under pressure, to make visible structures that could remain hidden in abstract analyses.

Such a method can be criticised. It can appear excessive, risky, self-referential or aesthetically problematic. But it must not be translated into a personality diagnosis without analysing its methodological and artistic context.

The author had submitted the materials precisely so that the clinic could understand the function of his self-presentation within the body of work. If the works were not read, or were judged only superficially according to visible characteristics — self-portraits, self-publishing, leading role in his own film — their purpose was reversed. Evidence that was supposed to explain the life and work profile became apparent evidence of self-aggrandisement.

Methodological self-use was read as psychological self-reference.

Self-Irony and the Figure of Failure

The questionable nature of this interpretation became particularly clear in the feature film *Transferprotokoll, which apparently occupied the diagnostician in particular*. In doing so, she apparently fell for precisely the dramaturgical device of the entire film. In *Transferprotokoll*, the author played himself as an artistic persona who drives authorities mad. He deliberately played within a field of tension between clownish arrogance and victimised failure. Precisely this could and was intended to trigger resentment, while at the same time contrasting this tension with the real social injustices of German social legislation surrounding *Bürgergeld*. The self-confident poor person making demands of the state was a deliberate provocation. That the author worked artistically in this way was publicly known. With a little diligence in reading the facts, this should have been recognised.

The author did not in fact present himself in the film as a triumphant, admirable or superior figure. He played a failing, partly clownish protagonist who fought against injustices in the welfare system. In the role, he presented himself with the lowest imaginable status.

The work therefore rested substantially on self-irony.

Self-irony does not exclude narcissistic traits. Nor does it exclude autism. People with narcissistic traits can also ironise themselves or strategically use a self-deprecating role. It is therefore not counter-evidence in the strict sense.

But it should have been incorporated into the assessment. Above all, however, the professional-artistic justification should initially have been foregrounded, not the pathologisation of an artistic persona that was confused with the author.

Anyone who interprets self-presentation in the film as an indication of grandiosity must likewise consider how this figure is constructed: as hero or failure, as an admirable centre or as a vulnerable and ridiculous body, as confirmation of one's own greatness or as an instrument of social criticism.

The mere fact that the author played himself says nothing about this. It is also doubtful to assume that someone with narcissism would choose, in a feature film intended for television, to present himself precisely as a *Bürgergeld* recipient, in other words as someone with the lowest imaginable status.

The diagnostician repeatedly emphasised how extensively she had engaged with the film. She reacted exactly as the film intended, as was stated as the intention in the film's accompanying texts submitted to film festivals or held at the Federal Film Archive.

Grandiosity or Insistence on the Value of One's Own Work

For the author, the narcissistic attribution became particularly concentrated around the question of how his insistence on the value of his own work was read.

He entered the clinic as someone who had been unemployed for many years and received *Bürgergeld*, while simultaneously presenting books, papers, a film and a letter of recommendation from a well-known scientist. He explained that his work was scientifically and artistically relevant even though it had emerged outside universities, publishers and regular employment.

This constellation was socially unusual. It could easily appear contradictory: a person largely excluded institutionally who nevertheless asserted the value of his own body of work with great certainty.

Precisely for this reason, there was a considerable risk of classist misinterpretation. Particularly dangerous for an internationally known clinic such as Humboldt's.

The author, in turn, had no alternative but to foreground the body of work, because otherwise he had nothing that represented his life experience. He also had more prominent admirers, senior politicians, academics and well-known actors than an ordinary audience. Here too, he was entirely autistic.

An institutionally recognised professor can speak about the significance of their research, refer to publications, prizes, recommendations and citation counts and emphasise the social relevance of their body of work. This behaviour is ordinarily treated as part of professional self-description. If an impoverished, unemployed and academically unaffiliated author does the same thing, the same self-description can appear as self-overestimation.

The difference then lies not in the content of the statement, but in the status of the person speaking.

The professor is regarded as significant and is permitted to know this.

The unemployed person is regarded as insignificant and becomes suspicious as soon as they disagree.

A classist norm of permitted self-worth thereby emerges. Recognised persons are permitted to reproduce their recognition. Unrecognised persons are expected to adopt their institutional position as an appropriate description of their own value. Anyone who, despite poverty and exclusion, insists on the quality of their work appears not resistant but grandiose.

The diagnosticians therefore had to distinguish with particular care between two possibilities:

The author could be unrealistically exaggerating the value of his work.

Or he could, in an environment that systematically confused his status with his epistemic value, legitimately insist that his work first had to be examined.

It is difficult to demonstrate massive exaggeration when the body of work had been acknowledged by prominent public figures and represented three decades of life achievement in art and research.

Which possibility applied could therefore not be decided on the basis of presentation alone. The content of the body of work would have had to be examined. Precisely this had been uncertain from the outset. Already at the first appointment, the diagnostician had explained that she did not know whether she would have time to look at all the material. Nevertheless, the strong insistence on this material later apparently entered into the psychological assessment of the author.

It must also not be forgotten that the author repeatedly pointed out that he was gifted. He did so because he knew this was professionally highly relevant in autism assessment. One wants to understand how someone thinks. He did not do it in order to boast.

At the same time, it is only understandable that a gifted researcher who has conducted research at an inevitably high level for decades — anything else would also be boring — does not stop doing so because he is impoverished and his low status does not fit. Such a brain wants to confront major challenges. Naturally, no consideration is given to whether one simultaneously possesses the corresponding social status that would, according to social norms, permit one to do this.

Paradoxically, autistic people in particular often have difficulties balancing this.

The combination of autism and giftedness not infrequently leads to a particular form of apparent arrogance that can drive people up the wall. This also seems to have played a role here, or at least cannot be excluded, because Humboldt refused any clarification of the motives for the attribution of narcissism.

An asymmetric procedure resulted from this:

The clinic did not have to examine the body of work, but was permitted to interpret the author's insistence on its value.

Finally, it must also be said that artists are trained to represent their own value confidently. If they did not, they would be pushed aside everywhere. In doing so, they also defend their function in preserving democracy. In art, "presumption" is often a legitimate artistic device. One places oneself in a position in order to fill it with life and investigate conflicts within it.

It is a professionally learned characteristic. One also cannot accuse a NASA engineer of having obsessive-compulsive disorder because, before the rocket launches, they compulsively check everything very precisely once again.

The Missing Examination of Empathy

The report explicitly listed "deficits in empathic capacity" as a characteristic of a narcissistic person.

It remained unclear, however, what evidence for this existed in the concrete case.

The author had submitted an extensive body of work that had, over years, dealt with poverty, discrimination, institutional violence, health harms and the suffering of marginalised people. The preceding study on denied access to autism assessment had likewise not been formulated merely as a personal claim. It documented the situation of 1,667 people competing for approximately 25 places and attempted to make a structural problem visible through an individual case. The author repeatedly gave up self-protection and immediate personal advantage in the procedure in order to make the injustice itself public so that it might also help others.

Such a body of work does not prove unrestricted empathic capacity. People can engage politically or scientifically with suffering and nevertheless have substantial empathy deficits in personal contact. Conversely, communicative misunderstandings, emotional directness and atypical reactions can appear from the outside like a lack of empathy even where strong compassion is present.

Precisely for this reason, concrete exploration would have been necessary.

It would, for example, have had to be clarified whether the author regularly disregarded the feelings and needs of others, instrumentalised relationships, behaved exploitatively towards others, fundamentally placed his own claims above those of others, or had difficulty recognising the vulnerability of others.

No such account appears in the report. It would also have contradicted the descriptions of the partner and the psychotherapist friend.

Instead, the general characteristic of empathy deficits was incorporated into the description of the narcissistic accentuation without making visible what this characteristic consisted of in the author's case.

This was particularly problematic in the context of an autism assessment. Autistic communication can be experienced by non-autistic observers as cold, self-centred, impolite or insufficiently reciprocal. This does not automatically mean a lack of compassion. If a communicative mismatch is interpreted as narcissistic lack of empathy, a diagnostic confusion arises that can additionally be facilitated by the Double Empathy Problem.

The clinic should therefore have distinguished between at least three levels:

the capacity to recognise other people's feelings cognitively;

affective participation in the suffering of others;

and the capacity to make this participation visible in a socially expected form.

The report did not distinguish these levels.

It used the general concept of empathy deficit without explaining its concrete meaning in the case.

For a clinic specialising in social communication, the investigation of precisely this question was relatively thin.

Envy and Social Reality

The interpretation of envy remained similarly inadequate.

According to his memory protocol, the author explained that he envied people who held professorships. This statement was unsurprising against the background of his life history. He had researched and published for decades but had never been institutionally integrated into a university. A professorship represented income, workspace, scientific recognition, colleagues, library access, research capacity and the possibility of carrying out the same activity under secure conditions.

The envy therefore did not necessarily concern the person or their admiration. It could have been directed towards real resources and institutional opportunities.

Nor was the assumption that others might envy individual aspects of his independence automatically grandiose. The author had no academic career to protect and could therefore formulate positions more radically than institutionally embedded researchers. This freedom had been purchased through poverty, insecurity and exclusion. That some people might notice the freedom without fully seeing its costs is at least socially conceivable.

The diagnostic question should therefore have been whether the author was persistently convinced that other people envied him because of his exceptional greatness and superiority. A situational statement about possible envy of a particular freedom was insufficient for this. The author had explicitly ruled this out several times during the differential diagnosis. He repeatedly said that he only thought about envy at all when asked. Like most people.

Without deeper examination, a complex social observation was translated into a personality trait.

Three Books, One Film and the Problem of Context Loss

An unusually large amount of contextualising material was available within the procedure. Yet precisely the narcissistic assessment shows that quantity alone does not create epistemic certainty.

Three books and a film can contextualise a statement. But they can equally become material for misinterpretation if their function is not understood.

The author was visible on the book covers. In the film, he played himself. In conversation, he repeatedly referred to the significance of his body of work. He submitted a letter of recommendation and explained that his research had to be taken seriously.

From one perspective, this could produce an image of strong self-reference.

From another perspective, it showed a person who knew that his institutional status would be used against him and was therefore desperately trying to substantiate the reality of his own work.

Both readings were possible.

Precisely for this reason, the clinic could not simply psychologise one of them. It had to examine which interpretation fitted better with the entire biographical course, the relationships, the actual contents of the body of work and behaviour outside this extreme diagnostic situation.

The situational context was particularly susceptible to distortion. The author was in a procedure whose outcome carried substantial rights under social law and health consequences. He knew that only a few hours were available. He feared that his extensive material would not be read. Under these conditions, he referred repeatedly and with increasing intensity to his body of work.

It later became apparent that the body of work had indeed received hardly any visible weight in the assessment of the special interest. The author's fear had therefore not arisen out of thin air.

It happened exactly as he had feared and was what he had precautionarily warned Humboldt about beforehand through the analysis in Appendix 1. This warning was simply ignored by the university.

The Circular Pathologisation of Objection

The narcissistic accentuation became particularly dangerous within the feedback meeting itself.

The author objected to the decision with considerable intensity. He explained that the clinic had failed to understand central evidence, misjudged his special interest, insufficiently considered masking, and incorrectly classified the distinction between exhaustion and depression. In doing so, he referred to his own research and the materials submitted.

But if the hypothesis had already emerged that the author overestimated himself, required admiration and behaved arrogantly, every one of these objections could appear as confirmation of the hypothesis.

The author claimed that the diagnosticians had failed to understand his work: grandiosity.

He referred to the significance of his books and papers: self-aggrandisement.

He did not accept the report: inability to accept criticism.

He criticised the competence of the clinic: arrogance.

He insisted that he could explain the diagnostic classification better than the procedure: narcissistic superiority.

A hermetic structure thereby emerged. The more strongly the author attempted to correct what he regarded as a false interpretation, the easier it became to read his attempt at correction as a symptom of that interpretation.

The objection lost its epistemic content and was psychologised.

This is particularly problematic when the diagnosing institution is itself the object of criticism. Humboldt University was not merely the observer of a possible personality problem. It was simultaneously the institution that the author had sued, publicly criticised and scientifically investigated. His negative judgement about the clinic therefore directly concerned the persons and structures who could subsequently evaluate his attitude as arrogant or grandiose.

The institutional conflict and the personality assessment were not separated from one another.

The narcissistic attribution thereby acquired a political function, irrespective of whether this was intended: it could transform the author's criticism from a statement about the institution into a statement about his personality.

This was not the first time; see his book *Speed's Arbeit*, in which he experienced politically motivated pathologisation that served the political right in devaluing his criticism of state injustices.

The clinic no longer had to explain whether his criticism was correct.

The critic had to explain why he considered himself important enough to criticise the clinic.

The Pathologisation of the Epistemic Actor

The author had entered the procedure as an evidence-bearing patient. He possessed knowledge about his own biography, about autism research, about masking and about the structure of his body of work. He did not encounter the clinic as a passive recipient of clinical truth, but as an epistemic actor.

Precisely this could appear as a disturbance within the traditional diagnostic hierarchy.

The expected patient reports symptoms. The diagnostician interprets them.

The author, by contrast, did not merely report symptoms. He brought his own theory, extensive documentation and an already developed diagnostic hypothesis. He evaluated the procedures being used, criticised the ADOS, spoke about current research, contradicted the diagnostic categories and demanded accountability regarding the weighting of evidence.

He thereby shifted the distribution of roles.

The clinic could not readily treat him merely as the source of raw data. He claimed participation in their interpretation.

The narcissistic accentuation threatened to pathologise precisely this claim. His self-knowledge then appeared not as a possible source of knowledge but as grandiose certainty about himself. His professional criticism appeared not as a scientific objection but as arrogance. His insistence on the significance of his own long-term data appeared not as an attempt to preserve evidence but as an exaggerated sense of his own importance.

Epistemic competition was thereby decided through a clinical hierarchy.

The diagnosticians could be wrong, but their errors remained professional assessments.

The author could be right, but his insistence became a personality trait.

Thirty Years of Work Without Admiration

The biography additionally contained a substantial counterpoint to the thesis of a dominant need for admiration.

According to his own documentation, the author worked for approximately 27 years largely unpaid and institutionally unnoticed on his body of work. He published books, films and papers without reliable prospects of income, academic status or public recognition. For a long period, there was little response.

This does not prove that no need for recognition existed. On the contrary, a narcissistically structured person can also hope for later recognition over long periods. Vanity is also not a diagnosis.

But the extraordinary duration of an activity despite absent confirmation requires a more differentiated explanation. The work did not appear to be sustained solely by immediate admiration. Nor was it driven by narcissistic injury. It possessed an intrinsic, regulatory and binding function. The author continued to work on substantive topics even when hardly anyone was watching.

He said to the diagnosticians (memory protocol):

> *"I do not work out of emotional injury, but because I recognise patterns in systems. My entire body of work is motivated by making patterns visible and confronting contradictions that I cannot ignore."*

After decades of rejection of his body of work, if narcissism were the underlying mechanism the work should long since have been full of narcissistic injuries. Instead, it dealt with physics, psychology, autism and social injustices in society and economics.

Precisely therein lay a central indication of a possible special interest: the activity was not first motivated by social success. It continued without it.

A narcissistic explanation would have had to show how the assumed need for admiration remained stable over decades even though the activity provided hardly any of that admiration and instead led the author into poverty, insecurity and institutional exclusion.

No such explanation was provided.

Accentuation Without a Robust Derivation

The criticism of the narcissistic personality accentuation does not mean that the author could possess no narcissistic characteristics whatsoever.

People have narcissistic elements. Artistic work can be associated with vanity, desire for recognition and the wish to be acknowledged. Long-term institutional exclusion can also produce compensatory self-assertion, sensitivity to devaluation and strong defence of one's own value.

All of this could be investigated.

Precisely for this reason, it is important not to predetermine the outcome. The question is not whether every narcissistic interpretation was fundamentally impossible. The question is whether the present attribution was sufficiently examined, justified and differentiated from alternative explanations.

According to the documented data, this was not the case.

The assessment apparently rested on a few questions, situational observation within a highly stressful and conflict-laden setting, and an interpretation of artistic self-use. At the same time, central counter-

information existed: long-term work without recognition, pronounced self-irony, a body of work concerning the suffering of marginalised people, the methodological function of the author's own person, and a real institutional history in which the author was forced to assert the value of his unrecognised work particularly strongly.

A robust diagnostic justification would have had to integrate this counter-information.

The report did not visibly do so.

From Misinterpretation to Harm

For the author, the narcissistic attribution was not merely insulting. It had concrete social and legal consequences.

A university report can be read by courts, authorities and future treating professionals. The designation of narcissistic personality traits can influence how future statements by the person concerned are evaluated. Intense complaints then appear more easily as sensitivity to injury. Persistent pursuit of legal remedies can be read as entitlement. Criticism of institutions can appear as devaluation of others. Insistence on one's own expertise can count as grandiosity.

The report therefore does not merely change the description of the past. It structures the interpretation of future behaviour.

For a person who had already entered numerous institutional conflicts, this could be particularly damaging. His credibility was restricted not only in a specific autism question. A personality framework emerged within which every further act of resistance could be psychologised.

The diagnosis or accentuation thereby created the risk of a self-fulfilling file:

The author resists the attribution.

The resistance is read as narcissistic injury.

The attribution thereby appears confirmed.

Correction is thereby structurally made more difficult.

This is genuinely a central question. How could the author still have proven here that he experienced the world completely differently? If the submission of evidence was not taken into account by the Humboldt clinic. Into what kind of despair did this drive an already highly vulnerable person?

The author explained that he could not accept this.

> *According to his recollection, the older diagnostician then said, grinning arrogantly: "Go ahead, complain then."*
>
> *The author replied: "You have not the slightest idea what dramatic problems you are putting me into with this. It is hell that you are sending me into."*
>
> *For the diagnostician, it apparently seemed somewhat entertaining to let the author run into a wall. The clinic was completely indifferent to the consequences.*

The Unresolved Central Question

Narcissism did not explain why the author had been able to work for decades only under very specific conditions. It did not explain the extreme and enduring attachment to a coherent body of work. It did not explain the high masking and autism scores. It did not explain the discrepancy between situationally possible communication and long-term social and occupational failure. It did not explain the repetitive return to the same structural problems. It did not explain the severe states of exhaustion and decompensation. It did, however, offer a way to pathologise the manner in which the author pointed to all these connections.

Precisely his attempt to make the explanatory gap visible was thereby reinterpreted as the explanation itself. The author was not regarded as someone whose unusually extensive evidence may not have been understood. He was regarded as someone who grandiosely overestimated the significance of his evidence.

Here, perhaps the most consequential reversal of the entire procedure became visible: the institution's failure to integrate the epistemic actor was rendered readable as a personality problem of that actor. He was epistemically destroyed. With an arrogant smile and an incomprehensible lack of consideration.

Prof. Dziobek should have known how fatal the consequences for him would be.

The report therefore stated literally:

> *"F84.5 A Asperger syndrome; F34.1 G Dysthymia; Z73 G Accentuation of personality traits (narcissistic personality traits)."*

The abbreviation "A" indicated exclusion, while "G" indicated a confirmed diagnosis or finding.

For courts and authorities, this neither made explicitly clear that the concrete diagnostic setting may not have permitted a robust exclusion of autism, nor sufficiently distinguished between a narcissistic personality disorder and a mere accentuation of individual personality traits. Yet precisely this distinction is substantial: a personality accentuation is not equivalent to the diagnosis of a personality disorder. In the institutional further use of the report, there was therefore a danger that a formally limited and diagnostically weaker indication would be read as a more comprehensive psychopathological finding. The parenthetical wording "narcissistic personality disorder" intensified the conceptual ambiguity further because it suggested a disorder diagnosis even though formally only an accentuation of personality traits had been coded.

A personality accentuation refers to pronounced personality traits below the threshold of a personality disorder. It is not a weakened personality disorder and in particular does not permit the diagnosis of narcissistic personality disorder simply to be added in parentheses. In the present report, however, the Z73 code "accentuation of personality traits" was combined with the parenthetical designation "narcissistic personality disorder". This left unclear whether merely individual traits interpreted as narcissistic were being asserted or, contrary to the formal coding, a clinical personality disorder. For external readers, this could create the false impression of a confirmed narcissistic personality disorder.

This could serve to epistemically devalue the work and voice of the author who had previously publicly criticised and sued the clinic.

9. The Evidence-Bearing Patient and the Hierarchy of Diagnostic Knowledge

With the completion of the chronological reconstruction, the question posed by this investigation changes. Up to this point, it has documented which information was available, which diagnostic steps took place, how the result was communicated, and at which points contradictions arose. It is now necessary to examine what epistemic architecture this procedure possessed: Who was permitted to produce knowledge? Which forms of knowledge counted as diagnostically relevant? Who was permitted to determine their meaning? And what happened when the patient did not merely report experiences, but already possessed a developed, documented and scientifically reflected interpretation of his own life?

The author did not approach the Special Outpatient Clinic as an epistemically empty person. He appeared with an extensive folder, several books, scientific papers, autobiographical long-term documents, numerous screening scores, informant assessments and a scientific statement written in advance. (Appendix 1.) In addition, there was a publicly documented body of work spanning almost three decades that made visible precisely the structure of thought, work and attachment that formed the object of the diagnostic investigation.

For such a constellation, there is so far no sufficiently precise clinical term. The expression *expert by experience* captures the fact that people can acquire particular knowledge about their condition and the circumstances of their lives through long-term personal experience. In the present case, however, more than experiential knowledge was involved. The experience had been documented, theoretically processed, published and, for the most part, made verifiable by third parties.

The author is therefore referred to in the following as an **evidence-bearing patient**.

This does not mean a person whose self-assessment must be correct simply because of the quantity of material submitted. Even a thousand pages can be erroneous, selective, circular or shaped by a hypothesis that has already become entrenched. An evidence-bearing patient does not automatically possess diagnostic authority. Rather, the concept refers to a person who does not merely offer the diagnostic institution memories and momentary self-reports, but already brings with them a structured body of material whose epistemic status requires separate examination.

The diagnostic task thereby changes.

In an ordinary anamnesis, the professional attempts to construct a previously non-existent picture from answers, observations and available informant information. With an evidence-bearing patient, an extensive picture already exists. The task now consists not only in collecting further data. The institution must position itself in relation to an already existing structure of knowledge. It must examine what within it is robust, where false conclusions lie, which alternative explanations are more convincing, and what relationship exists between the clinical model and the already documented model of the person's life.

In the procedure examined here, this altered task was not explicitly recognised.

This is a problem not only because Prof. Dziobek speaks extensively about participatory research, but also within many other discourses surrounding Critical Autism Studies. What participation do presumed autistic people have in procedures that decide over their identity?

And autism is substantially also a question of identity, similar to homosexuality.

The clinic physically accepted the material. Individual books were picked up, papers remained at the institution, questionnaires were evaluated and informant histories were conducted. It nevertheless remained unclear which parts were actually read, how they were examined and with what weight they were introduced into the case conference. Already at the first appointment, the diagnostician explained that she did not know whether she would have time to look at all of the material. At the same time, the final judgement was supposed to rest on a comprehensive "overall assessment".

A fundamental contradiction thereby emerged: the procedure claimed to assess the whole without ensuring that the most extensive representation of that whole could enter into the procedure.

A massive methodological error was already present here.

This constellation can be described, following Havi Carel and Ian James Kidd (2014), as a form of epistemic injustice in healthcare. Patients can be treated as less credible subjects of knowledge precisely with regard to their own experience, functional history and the significance of their symptoms because clinically authorised knowledge is structurally weighted more highly. The problem is not that medical expertise is meaningless. It arises where institutional expertise does not critically receive the patient's experiential knowledge, but is already placed above it by virtue of status. The evidence-bearing patient is then not treated as a partner in knowledge production, but as a source of raw data whose meaning is determined exclusively by others.

The Patient as a Supplier of Raw Data

Traditional diagnosis rests on an epistemic division of labour. The patient reports experiences, symptoms and life events. The professional classifies this information, examines differential diagnoses and translates it into a clinical category.

This division of labour is initially sensible. The person being assessed has privileged access to their own experience, but does not automatically possess the clinical distance, comparative experience or methodological competence required for diagnosis. Conversely, the diagnostician possesses professional knowledge and possibilities for comparison, but has only limited access to the actual life of the person being assessed. Particularly when neurotypical diagnosticians are attempting to recognise autism or ADHD.

Both sides therefore possess different forms of knowledge.

The division of labour becomes problematic when this difference becomes a fixed hierarchy:

> *The patient may supply content. The institution alone decides what this content means.*

Precisely this structure became visible in the present case. The author could report on his work, exhaustion, communication, relationships and childhood. He could submit his own books, documents and test results. He could not, however, trace which statements were taken up, how they were noted, and with which diagnostic concepts they were connected. The diagnosticians' hypotheses remained invisible, while his statements continuously entered into their model.

He was therefore recognised as a source of data, but not as an equal participant in their interpretation.

This distinction is central. A person can be questioned comprehensively about their life and still remain epistemically excluded. They are permitted to speak without knowing what picture is emerging from their speech. They can correct information as long as it still appears as individual facts. But they can hardly intervene once these facts have been internally condensed into a psychological structure.

The patient is present, but not present in the formation of meaning. This raises ethical questions that will be examined later in the paper.

The Institutional Added Value of Clinical Interpretation

That a professional interprets data is not an error. Precisely this constitutes a substantial part of diagnostic competence. The professional is supposed to identify patterns, examine contradictions, weigh alternative explanations and prevent a plausible self-explanation from being prematurely equated with a clinical diagnosis.

This competence, however, cannot simply be assumed. It must show itself in the quality of the distinctions made.

In the present case, the question therefore arises:

> *What did the clinical interpretation actually add to the already existing data?*

Possible answers would be:

- It could have identified contradictions between different statements.
- It could have identified characteristics that the author himself had overlooked.
- It could have explained the high screening scores through a better-fitting alternative model.
- It could have distinguished between long-term structures and current reactions to burden.
- It could have situated self-presentation, compensation and situational behaviour within a consistent life course.
- It could have examined the quality and diagnostic relevance of the long-term evidence submitted.

All of this would constitute a legitimate epistemic added value of clinical diagnosis.

In the written report and the feedback meeting, however, this added value became visible only to a limited extent. The clinic named the result, individual test scores and alternative diagnostic concepts. But it did not present a traceable reconstruction showing how the clinical interpretation resolved the existing contradictions better than the autism hypothesis.

The authority of the interpretation therefore rested less on its transparent justification than on its institutional origin.

The diagnosticians counted as those who were permitted to classify. The patient counted as the one whose classification itself could become an object of diagnostic assessment.

The submitted texts were not mentioned with a single word in the report. From this omission one might infer that they had no significance, meaning that they were not taken into account. At least not in terms of their substantive quality; rather, it seemed that the circumstance that the patient had submitted data in considerable quantity was itself used as a diagnostic characteristic.

One can see here how certain potentially autistic profiles were treated unequally. The external observability of social deficits stood in the foreground. Monotropism, Double Empathy and the inner experience of an autistic person would largely have been found in the material.

This appears all the more absurd in the case of a 53-year-old person, given that the clinic devalued the evidence in this way.

Unequal Consequences of Error

This hierarchy becomes particularly problematic because errors on both sides are treated differently.

The patient can be wrong. He can read research one-sidedly, adapt answers to a desired diagnosis, retrospectively reinterpret memories or overestimate the significance of his own characteristics. His possible fallibility is therefore explicitly made an object of the procedure.

Diagnosticians can also be wrong. They can misunderstand statements, abbreviate notes, fit unusual biographies into familiar patterns, insufficiently take current research into account or fail to recognise their own institutional assumptions. This fallibility, however, is made far less visible within the procedure.

The patient's errors count as diagnostic data.

The institution's errors initially count as professional assessments.

A structural inequality arises from this. If the author, who himself researched autism, regarded his own work as diagnostically central and the clinic interpreted this as overvaluation, this interpretation could later even contribute to the justification of narcissistic personality traits. If, by contrast, the clinic possibly underestimated the decades-long attachment to the body of work, there was no institutionally prescribed procedure in which this underestimation had to be reviewed before the report was finalised.

The patient's error could be pathologised.

The diagnostician's error remained protected by her role.

If a clinic such as Humboldt's overextends its own authority here and, as happened in this case, no longer engages with the patient's objections at all, it forfeits trust in the quality of the diagnostic process itself.

In view of the deficiencies set out here, the question must then be asked whether an assessment at such a clinic can still be relied upon at all.

Given the number of people presenting to Humboldt for assessment, this could quickly amount to a massive liability risk.

Quantity of Evidence and Epistemic Capacity for Reception

The case simultaneously shows that a large quantity of evidence does not automatically lead to greater diagnostic accuracy.

On the contrary, unusually extensive material can overwhelm a resource-limited procedure. The institution has fixed time windows, standardised instruments, billable services and a limited number of case conferences. It is designed to produce a decision from a manageable quantity of clinically usable information.

An evidence-bearing patient disrupts this architecture.

He brings more material than the format can absorb. His life is available not only in narratives but in books, films, papers and files. The more extensive this material is, the more difficult its integration becomes within a procedure whose time structure was standardised before the concrete case was even known.

A paradoxical relationship thereby emerges:

> *The better a patient has documented their life, the greater the danger may become that their evidence is epistemically devalued because of institutional overload.*

The problem is not that a clinic would have to read every page of a thirty-year body of work. Such a demand would be practically unrealistic. It would, however, need a procedure through which extensive long-term evidence could be incorporated in an ordered manner. It would have to select transparently which parts it regarded as diagnostically relevant, why it did not take others into account, and what limitation this created for the certainty of the judgement.

Precisely these intermediate steps remained invisible.

The material was not comprehensively refuted. It was apparently kept largely outside the decisive production of knowledge.

In an autism assessment of a 53-year-old, this is grossly negligent.

Scientifically, this is extremely concerning. Because evidence is then evaluated not according to substance or content, but according to convenience.

For a university such as Humboldt, this is shameful.

The Reversal of the Evidential Relationship

Normally, a diagnosis is supposed to explain a life. In the present case, however, the impression arose that the life first had to adapt itself to the absorptive capacity of the diagnostic format.

The procedure did not primarily ask:

> *What form of investigation would be necessary to capture this unusually well-documented life course adequately?*

In practice, it asked:

Which parts of this life course can be processed diagnostically within the available instruments and time windows?

The evidential relationship was thereby reversed.

The material did not determine the necessary depth of the investigation. The available investigation determined which material could appear relevant.

This reversal particularly affects adults diagnosed late. In them, autism is not to be sought only in individual observable behaviours. It may show itself in decades-long patterns of work, relationships, overload, compensation, failure and self-organisation. The older and more complex the person, the less plausible the assumption becomes that a few hours of direct observation should automatically possess epistemic priority over the entire life history.

The clinical encounter sees the person in the room.

The biography shows what that person was able to do over decades under changing conditions and where they failed.

Both are relevant. But they are not the same kind of data. This becomes particularly problematic for older people.

The Body of Work as a Biographical Long-Term Instrument

In the author's case, the body of work was not merely an expression of artistic or scientific achievement. It was a long-term instrument of self- and world-observation.

Across almost three decades, the work repeatedly returned to particular structural problems. It documented conflicts, modes of thought, institutional experiences, attachments and the conditions under which productive activity remained possible. The body of work therefore possessed a diagnostic function that went beyond an ordinary occupational description.

In addition, the author repeatedly published as a researcher on autism.

To say that a person works as an artist or researcher would be diagnostically of little value.

To show that a person has worked almost full-time for nearly three decades, largely unpaid, despite poverty, lack of institutional recognition and repeated health breakdowns, on a coherent body of work that may show many indications of autism, some of which were even presented in international autism research in this case, is something else.

The material could provide indications of:

- unusual duration and intensity of object attachment;
- low interruptibility;
- recurring structural themes;
- dependence of capacity for action on self-determined working conditions;
- a strong difference between self-directed work and externally organised employment;
- regulatory functions of the activity;

- and the long-term intertwining of work, identity and psychological stability.

None of these characteristics proves autism in itself. In combination, however, they create a substantial diagnostic need for explanation.

In addition, the author contributed scientific work to autism research in which connections between his own experiences and autistic interpretation were discussed. Simply ignoring what a colleague was researching appeared extremely questionable, if not disrespectful, here.

If a clinic cannot examine such a body of work substantively, it must at least acknowledge that a central part of the long-term evidence remains unexamined. It cannot simultaneously use the material indirectly against the person by interpreting their insistence on its value as self-aggrandisement while devaluing its content.

Otherwise an irresolvable circle emerges:

> *The body of work is not examined because it is too extensive or insufficiently institutionally authorised. The author's insistence on its significance is subsequently evaluated as a psychological characteristic. Precisely this evaluation then serves to further relativise the credibility of his self-assessment.*

The evidence is not refuted.

The bearer of the evidence is reinterpreted.

Epistemic Objectification

This structure can be described as **epistemic objectification**.

The patient becomes an object of knowledge without being recognised in the same way as a producer of knowledge.

The person is permitted to provide information about themselves.

They are not, however, automatically permitted to participate in deciding what their information means.

This raises massive ethical questions, particularly because statements by neurodivergent people have often been marginalised in scandalous ways throughout the history of neurodivergence research, in part to defend theories that were at times absurd.

The guiding principle "**Nothing About Us Without Us**" comes from the international disability rights movement. It was spread particularly through self-advocacy organisations of disabled people and expresses the claim that research, decisions or action concerning disabled people must not take place without including them as equal holders of knowledge and decision-making power. James I. Charlton made the phrase a central theoretical concept of Disability Studies with his 1998 book *Nothing About Us Without Us: Disability Oppression and Empowerment*; the United Nations likewise adopted it as a principle of full participation.

Kristie Dotson's (2011) concept of epistemic violence or epistemic silencing extends this problem beyond the mere reduction of individual credibility. A person can speak at length and still be epistemically silenced if existing institutional categories cannot or will not receive their statement as relevant knowledge. In the present case, the problem therefore did not necessarily consist in the author having no voice. It consisted in his voice being able to lose its corrective and knowledge-bearing function within diagnostic processing.

The author did not merely have a different interpretation of individual symptoms. He represented a different model of autistic cognition, communication and attachment. Thus, it was not merely patient and diagnostician who encountered one another, but two epistemic perspectives on autism.

The institutional perspective, however, possessed sole power of coding.

The Clinical Hierarchy as Self-Protection

A hierarchy of knowledge does not merely serve professional ordering. It also protects the functionality of the institution.

If every extensive self-documentation automatically forced an equal scientific examination, many clinics would be organisationally overwhelmed. Diagnostic systems therefore require rules of selection. They must determine which materials can be considered, and to what extent.

The problem lies not in selection itself, but in the lack of disclosure.

If an institution can in practice absorb only a limited amount of biographical evidence, it would have to communicate this transparently to patients. It would have to say:

> *Our procedure can examine certain complex long-term data only to a limited extent. A negative result therefore has limited validity in these domains.*

Instead, the resource limitation remains in the background while the result is communicated with the weight of university expertise.

The organisational limitation does not appear as a limitation of the institution.

It appears as a limitation of the patient's evidence.

"We could not examine this material in full" effectively becomes:

> *"This material was not sufficiently convincing for the diagnostic result."*

These sentences are not identical.

In the first case, the limitation lies with the procedure.

In the second, it lies with the person and their material.

Precisely here begins the later ethical question of whether resource scarcity is being transformed into a statement about the patient's reality.

The question must be asked whether it is scientifically legitimate at all to conduct autism assessment if one is unwilling to provide the resources required for it. What is such a diagnosis still worth from a scientific perspective?

May a clinic publicly claim that it determines whether autism is present if it has to erase large parts of the evidence in advance merely in order to implement its procedure at all?

What stands in the foreground here? The welfare of those affected, or the welfare of the clinic?

And what must this insight mean internationally for autism assessment? This could indicate the beginning of a massive crisis.

The Disappeared Right of Correction

An evidence-bearing patient does not require the right to enforce their desired diagnosis. They do, however, require the possibility of recognising and correcting substantial misunderstandings before the report is finalised.

No such feedback procedure was provided for in the procedure examined here. The author could object during the feedback meeting, but by that point the internal judgement had already been formed. The case conference had taken place, observations had been condensed and diagnostic categories assigned.

Correction was no longer part of knowledge production. It was refused because of resource scarcity.

This also changed the meaning of objection. Before the decision, an objection could have counted as additional information. After the decision, the same objection could appear as lack of acceptance, narcissistic injury, arrogance or desire for diagnosis.

The timing of participation is therefore epistemically decisive.

A person is not participatively involved in an assessment merely because they are allowed to comment on the result at the end. Participation requires that their corrections can still influence the process through which the judgement is formed.

In the author's case, this possibility was not recognisably present. He was permitted to object, but the objection had no visible diagnostic effect. Not even when errors in the report were objectively demonstrated. The clinic could dispute this and refute it again, but it should not refuse to consider evidence.

But the Humboldt clinic under the supervision of Prof. Dziobek refused to re-examine refuted evidence.

This is particularly serious in a procedure that is supposed to be scientifically correct and has substantial legal consequences.

The author was pushed out under time and billing pressure.

The Asymmetrical Status of Self-Knowledge

Self-knowledge is neither infallible nor meaningless.

People can be mistaken about themselves. At the same time, they can know aspects of their experience that are not directly accessible through any clinical observation. These include the costs of social interaction, the conscious construction of eye contact, exhaustion after a conversation, the function of a special interest, the internal effort of transitions, and the difference between visible competence and actual resilience.

Particularly in the case of masking, self-knowledge is not merely supplementary information. By definition, it concerns processes that are designed not to be visible from the outside.

An assessment that weights visible behaviour more heavily than the description of concealing that behaviour therefore enters into a methodological circle:

> *Successful masking is not recognised because it is successful. The lack of visibility is then used as evidence against the presence of the masked characteristic.*

This does not mean that every self-report concerning masking must be accepted without examination. It means that its rejection must not rest solely on the absence of visible abnormality.

The patient's self-knowledge must be examined.

But it must not be devalued because it is self-knowledge.

Work by Monique Botha (2021) shows that autistic people in autism knowledge production frequently remain both objects of research and epistemically marginalised speakers. Their knowledge is more readily classified as subjective, activist, emotional or identity-political, while clinical and academic perspectives appear neutral. Precisely this asymmetry becomes visible in the present case: the author's intensive scientific engagement with autism did not necessarily increase recognition of his expertise, but could itself be read as an expression of diagnostic fixation or a desired outcome.

The Epistemic Core of the Case

The case examined here is therefore not merely a dispute about the correct diagnosis.

It is a conflict over the hierarchy of knowledge.

On one side stood an institution with clinical authority, standardised instruments, a case conference and the power to produce a finding with social and legal effect.

On the other stood a person with decades of knowledge of his own life, extensive documentation, high screening scores, professional background knowledge, his own research and a developed explanation of his functional profile.

The institution did not have to adopt this explanation.

But it did have to show why its own model explained the available data better.

Precisely this was actively refused by the diagnosticians. Critical questions about it were not answered.

Instead of an open confrontation between two testable explanatory models, a hierarchy emerged in which only one possessed the status of a legitimate diagnostic interpretation. The patient's model itself became an object of clinical interpretation. The institution's model, by contrast, remained the authority permitted to decide not only the diagnosis but also the epistemic value of the counter-model.

This created a structural imbalance:

> *The clinic could diagnose the author's interpretation. The author could criticise the clinic's interpretation, but could not participate in its formation.*

Precisely therein lies the epistemic disempowerment of the evidence-bearing patient.

In a case such as this, it appears particularly massive at Humboldt. What, then, must it look like for patients who bring no scientifically developed documents with them but directly describe their own perceptions?

The problem is not that the institution reached a different conclusion. Scientific and clinical assessments may differ from one another. The problem is that the disagreement was not organised as a conflict between two testable explanatory models. The institutional model was given priority before its superiority had been transparently demonstrated.

The massive weaknesses of the resource-scarcity-driven procedure were likewise not made nearly transparent enough. The author, as a researcher, possessed prior knowledge here; ordinary patients do not. They cannot assess how error-prone the system is.

The evidence-bearing patient was thereby returned to the role the procedure had provided for him: he was permitted to supply data. The meaning of those data, however, remained the property of the institution.

The institution thereby protected itself. Possibly at the expense of very many people affected.

The following chapter now examines more precisely how this meaning was produced. For between a person's life and the later report there is no immediate act of knowledge. In between lies a transformation chain of questions, answers, observations, notes, selection decisions and interpretations. Clinical subjectivity does not disappear within this chain. It becomes institutionally invisible.

10. The Double Subjectivity of Clinical Interpretation

Autism assessment usually distinguishes between subjective self-reports and clinical judgement. Questionnaires, autobiographical reports and assessments by close reference persons are regarded as important sources of information, but are regularly accompanied by the qualification that they are subjective and must therefore be contextualised through professional observation and an overall diagnostic assessment.

This distinction is fundamentally understandable. People do not possess neutral access to themselves. Memories change, current burdens colour retrospective evaluations, diagnostic expectations can influence answers, and complex life phenomena cannot be derived from self-reports alone.

The distinction becomes problematic where clinical interpretation is tacitly assigned an objective status.

The interview does not eliminate the subjectivity of self-report. It adds the subjectivity of the diagnostician and equips this second subjectivity with institutional authority.

This sentence identifies a central methodological conflict in the procedure examined.

The author answered numerous standardised questions, submitted earlier screening scores, reported extensively on his life course and underwent informant histories. These data were subject-bound. They rested on his memories, his self-perception and the perceptions of close reference persons.

In the interview, however, these statements did not remain in their original form. They were selected, shortened, noted, interpreted and assigned to diagnostic categories. Between the experience and the later finding thus stood a second person with their own expectations, theoretical assumptions, time limits, comparison cases and institutional obligations.

A subjective statement did not become an objective fact. It became a clinically authorised interpretation.

This resulted in gatekeeping. Gatekeeping, however, is not a scientifically legitimate process. It is an administrative practice.

From Life to the Finding

Between the actual life of a person and the final diagnosis lies a multi-stage chain of transformation:

> *Life → memory → answer → follow-up question → note → interpretation → case conference → finding.*

Each stage changes the material.

The lived event is more extensive than the memory of it. The memory is more extensive than what can be expressed in a concrete situation. The answer depends on the form of the question. The note contains only an excerpt of the answer. The interpretation assigns this excerpt to an already existing conceptual system. In the case conference, individual observations are summarised again. The written finding finally reduces the entire chain to a few diagnostic statements.

A team conference does not merely combine different opinions, but can also reinforce a collective BIAS. Under group pressure, concerns are expressed differently. There is a greater tendency to smooth unusual results.

This reduction is, of course, unavoidable. No medical report can reproduce an entire life. The scientific question is therefore not whether reduction occurred, but how.

Which information was lost?

Which remained?

Which was altered in its meaning?

Which uncertainties disappeared during condensation?

And which interpretations ultimately acquired the status of facts?

In the procedure examined, these transitions were hardly visible to the author. He could give his answers, but could not examine how they were recorded. He could not see which formulations emerged from them and which connections were preserved in the internal discussion. Only during the feedback meeting were individual notes shown to him on a monitor. According to his documentation, this occurred through rapid scrolling, so that systematic examination was impossible.

Precisely that part of the procedure in which statements became clinical meaning therefore remained invisible.

The question is why anyone should trust a clinic if it cannot communicate its results in a traceable and reviewable manner? If, in the end, only authority remains as legitimation.

This may be a secondary question in clinical practice. In the consideration of fundamental human rights, it is not. In science too, we see here basic conditions from which statements described as true can first be derived, if at all.

Autism assessment is an industry. But on what does it base its capacity to decide?

With the concept of the clinical gaze, Michel Foucault (1973) described an order of knowledge in which the person being examined becomes a clinical object through medically defined forms of visibility and speakability. For the present case, what matters less is a general critique of medicine than the question of which parts of a life can appear diagnostically existent within this gaze at all. What cannot be translated into the prescribed questions, observational categories and report forms risks not merely being disregarded, but disappearing from clinically effective reality.

The Question Produces a Range of Answers

A diagnostic question does not merely collect information. It simultaneously determines what kind of information can become answerable.

The question “Do you avoid social situations?”, for example, produces a different kind of knowledge from the question:

> *“What exactly happens in social situations, what burden arises there, and why do you avoid them?”*

The first question can produce a high score on an anxiety scale. The second can distinguish between fear of evaluation, sensory overload, communicative uncertainty, exhaustion and negative learning experience.

The same applies to questions concerning recognition, envy or self-worth. Asking whether an author is pleased by praise for a book initially captures an ordinary human reaction. Only follow-up questions

could show whether recognition produces appropriate pleasure or whether there is a persistent, insatiable need for admiration.

Diagnostic meaning therefore does not simply reside in the answer. It emerges from the combination of question, context, follow-up and interpretation.

If this combination is not later disclosed, the diagnostic statement appears as though it had already been fully contained in the original answer.

This was particularly visible in the narcissistic personality accentuation. Individual answers concerning praise, professorships and possible envy were placed into a personality framework. The report, however, did not make transparent which additional questions had been asked, which counterexamples had been examined, and which biographical patterns had actually been established.

Clinical interpretation thereby appears as the discovery of a characteristic.

But it is equally possible that it first produced the characteristic through the specific ordering of the answers.

One can say that autism assessment cannot accomplish this. But what does it accomplish then? And is that adequate when people are made to wait years for a diagnostic appointment? Those affected expect a scientifically sound clarification.

The Note as an Epistemic Bottleneck

The diagnostician's written note possesses unusually great power within the procedure.

It is not a neutral record. It is a selection.

While a patient speaks, the professional decides:

- what is noted;
- how extensively it is noted;
- which wording is used;
- whether a statement appears as a direct quotation, summary or interpretation;
- whether the situational context is included;
- and which statements are regarded as diagnostically significant.

The note subsequently becomes the basis for further interpretation. Other team members may no longer encounter the original statement, but only its condensed form. In this case, only after six weeks.

From:

> *"I envy people with professorships for their institutional security, income and the possibility of conducting research under recognised conditions"*

can emerge, in a heavily abbreviated note:

> *"Envy of professors."*

From:

"Some people may envy me the freedom to write radically without academic constraints, even though this freedom is purchased through poverty"

can emerge:

"Believes others envy him."

Neither abbreviated statement is entirely false. But they change the meaning substantially.

The context explains the object and the social reality of the feeling. The abbreviation leaves primarily the diagnostically compatible concept behind.

The more strongly the material is condensed, the more easily a complex statement can fit into an existing category.

All of this may be secondary if one is diagnosing a cold, but it becomes a gigantic problem when the issue is a lifelong diagnosis that massively shapes the life of the person concerned.

Observation Is Theory-Guided

Clinical observation too is not immediate seeing.

A diagnostician does not simply observe behaviour. She observes behaviour in the light of particular diagnostic expectations. Eye contact, conversational flow, gesture, reciprocity, narrative style and responses to tasks acquire their meaning from a theoretical model.

That a person maintains eye contact is initially an observable fact. Whether this speaks against autism, however, depends on further assumptions:

- Was the eye contact spontaneous or consciously controlled?
- What costs did it cause?
- Had it been trained over decades?
- Was it easier in a structured one-to-one interaction than in everyday life?
- Did it serve precisely as masking?
- Did it actually correspond to natural social orientation or to a learned rule?

Observation alone does not answer these questions.

The same applies to social reciprocity. A highly verbally competent person can respond to questions, use humour and sustain a conversation. It does not automatically follow that social interaction is effortless, intuitive or stable across different situations.

Clinical observation therefore itself requires interpretation.

It possesses no automatic priority over self-report.

How spontaneous is eye contact still when one is engaged in a legal dispute with a clinic and that clinic is deciding over one's life?

From a scientific perspective, should the clinic not have had massive doubts about its own measurement data here?

The Difference Between Standardised and Open Data

Questionnaires have clear limitations. They simplify complex experiences, rely on self-report and can be influenced by response tendencies. At the same time, they possess a methodological advantage: their structure is visible.

The person being assessed knows the question.

The answer is available.

The evaluation follows a fixed rule.

The resulting score can be checked.

The clinical interview is more flexible and can explore connections in greater depth. Precisely this flexibility, however, makes its evaluation less transparent. Not every person receives the same follow-up questions. Not every answer is documented with equal detail. Diagnostic relevance arises through the interaction between patient and professional.

The more open the procedure, the greater the potential epistemic gain.

At the same time, dependence on the competence and assumptions of the interviewer increases.

In the author's case, several clearly elevated standardised results were present. At the same time, the clinical interpretation reached an opposing overall judgement. Such a contradiction is possible in principle. Standardised screenings can produce false positives, and clinical diagnosis may correct them.

Precisely then, however, it must be shown in what way the clinical interpretation was superior.

Which answers were misleading?

Which factors distorted the scores?

Which concrete observations contradicted them?

Which alternative explanation captured the entire response pattern better?

Without such an account, clinical flexibility becomes clinical unreviewability.

When those affected object, this becomes a substantial scientific and legal deficit of the procedure. Particularly when diagnosticians, as in this case, can no longer explain after six weeks how they arrived at particular decisions.

Breadth of Questionnaires and Depth of Interviews

If one mentally spreads out the numerous questionnaires across the floor, as already mentioned, a high density of questions emerges concerning social interaction, routines, repetitive interests, sensory experiences, masking, exhaustion, autonomy, attention and everyday life.

Taken together, they capture far more individual situations than a several-hour interview.

This does not mean that they are automatically deeper. An interview can reveal connections through a single example that ten standardised questions miss.

But the opposite is also possible.

An interview can touch central domains only briefly, while questionnaires generate a stable pattern across numerous items. If the two levels contradict one another, one must therefore not automatically assume that the interview is closer to the truth.

The decisive question is:

> *What did the diagnostician know after the interview that did not already emerge from the answers themselves?*

Was it a contradiction?

An alternative motivation?

An inconsistent biography?

A recognisable response style?

A discrepancy between behaviour and self-presentation?

Or merely a different clinical impression?

The difference is substantial.

A concretely demonstrated contradiction can weaken a self-report.

A mere impression itself requires justification.

And did the interviewer even know about the other established data? Because precisely this might have changed the questions substantially. She could have followed up much more precisely if she had known what the author had already answered in the screening tests, for example in the RAADS-R.

If a clinic cannot do this, it must not pretend otherwise to the detriment of patients, as happened here. It must then explain its incapacity and may in practice thereby give up its task. But it must not simply continue without being able to provide objective reasons for its decisions.

Subjectivity as an Asymmetrical Objection

In the case examined, subjectivity was used primarily against evidence that supported autism.

The author's own assessment was subjective.

The partner's informant history was subjective.

Even the opinion of the psychotherapist friend was labelled subjective, although she had explicitly been asked by telephone for a professional opinion, which was then omitted from the report.

The screening scores rested on subjective answers.

The clinical counter-interpretation, by contrast, was not presented with equal intensity as a subject-bound perspective.

An asymmetrical use of the concept thereby emerged.

Subjectivity was not treated as a general characteristic of all forms of knowledge involved.

It became a weakening argument against particular sources.

The problem is not that self-reports were relativised. That is necessary. The problem is that the relativising authority did not disclose its own relativity in the same way.

The Doubling of Possible Distortion

The interview can correct a self-report. But it can also introduce an additional distortion. The person can be mistaken in their answer. The diagnostician can misunderstand the answer.

The person can forget important context. The diagnostician can fail to note the context that is present. The person can misinterpret a behaviour. The diagnostician can prematurely assign its meaning to a familiar category.

The interview is therefore not a filter that removes subjective distortion. It is a second interpretive system that can both reduce and increase distortion.

Its scientific value depends on whether correction mechanisms exist. Without possibilities of correction, projections will inevitably occur.

Safeguards against this danger could include:

- verbatim documentation of central statements;
- follow-up questions about intended meaning;
- transparent summaries during the conversation;
- access to essential anamnesis findings;
- the possibility of correction before the case conference;
- and open presentation of contradictory interpretations.

In the procedure examined, such mechanisms were not recognisably provided for in a systematic way.

The Missing Feedback Loop

A diagnostician could say during an interview:

> *"I currently understand your statement to mean that you strongly require recognition and experience the lack of recognition as unjust. Is that correct?"*

The patient could answer:

> *"No. I want you to distinguish between the real value of the material and my institutional status. I am not concerned with admiration, but with you examining the evidence I have submitted."*

The conflict would thereby become visible.

The diagnostician could still arrive at the view that the statement contained narcissistic elements. But she would now have to explicitly take the alternative meaning into account.

Without such a feedback loop, an initial interpretation can continue operating unnoticed. Later statements are then already read through the lens of the first hypothesis.

This is particularly dangerous in personality assessment. Once a person appears grandiose, easily injured or lacking insight, further objections can confirm this reading. The diagnostic hypothesis changes the perception of subsequent material.

Interpretation becomes an observational filter.

It should be pointed out here that during the differential diagnosis the forms completed on the tablet were indeed checked for contradictions by repeating them through an additional conversation, but the in-depth interview was not. A young diagnostician conducted this alone with the author. And in a single pass.

Why, then, was this done on one side but not on the other?

The Epistemic Role of Silence

A lack of response also produces meaning.

The author repeatedly reported that diagnosticians hardly responded to central theoretical and biographical objections. A younger diagnostician had mostly nodded without revealing how she understood his statements. In the feedback meeting, central objections had not been answered substantively, but repeatedly referred back to the overall assessment or the clinical requirements.

For the institution, silence can mean professional neutrality. The diagnostician may not wish to steer the conversation, give premature feedback or disclose an ongoing hypothesis.

For the patient, the same silence can represent a substantial epistemic burden.

He does not know:

- whether he was understood;
- whether his statement is regarded as relevant;
- whether a misunderstanding has arisen;
- whether a hypothesis is already working against him;
- or whether his words are entering the evaluation at all.

For a person with decades of experience of social misunderstandings, this uncertainty can create additional pressure to adapt. They may begin to explain more, add context and control their presentation.

Precisely this behaviour can subsequently appear verbose, self-referential, controlling or excessively intellectualised.

The diagnostician's neutral silence is therefore not neutral in its effects.

When the author mentions the age of the diagnosticians, this is not only because of the question of experience, but also because clinics frequently use cheaper personnel to reduce costs. This may also play a role when two diagnosticians are present during one part of the procedure, but only one during another appointment.

Observer Effects in the Diagnostic Space

The patient's behaviour does not arise independently of the setting.

The author was in an institution he had previously sued and publicly criticised. At first, he did not know which diagnosticians were aware of this. Later it became clear that at least two of them were informed. At the same time, according to his recollection, he was told that he did not need to "pretend".

Under such conditions, natural behaviour could hardly be expected.

The institutional history produced vigilance.

The significance of the diagnosis produced pressure.

The lack of clarity regarding the internal state of knowledge produced mistrust.

The diagnosticians' silence produced additional self-observation.

The limitation of time produced pressure to condense.

The author's reactions were therefore not merely characteristics becoming visible within a neutral space. They were in part responses to a space created by the institution itself.

An assessment that subsequently interprets these responses as pure personality traits ignores its own contribution to the situation.

It observes effects that it co-produces.

Scientifically, this is fundamentally untenable.

The Central Methodological Consequence

Clinical interpretation is indispensable. Precisely for this reason, it must be made visible.

The greater its freedom of judgement, the greater the duty to justify.

The more strongly it departs from standardised data, the more precisely it must show what this departure is based on.

The more far-reaching the negative judgement is for identity, rights and treatment, the less the transformation chain between statement and finding may remain hidden.

The central demand is therefore not that self-reports should fundamentally be weighted more highly than clinical assessments.

It is:

> **Different forms of knowledge must be examined symmetrically with regard to their limitations.**

Self-report is fallible.

Informant history is fallible.

Screening is fallible.

ADOS is fallible.

Clinical observation is fallible.

The overall assessment is fallible.

What is scientifically decisive is not to declare one of these levels infallible, but to weigh their error sources against one another visibly.

In the procedure examined, this symmetry was largely absent. The subjectivity of the patient was diagnostically processed. The subjectivity of the diagnosticians disappeared behind the institutional form of the finding.

The following chapter examines the instance in which these different data were supposedly brought together: the diagnostic overall assessment. It was meant to integrate the contradictions. In the present case, however, it was invoked precisely where its own functioning could no longer be traced. It therefore risked turning from a method of evidence integration into an epistemic black box.

11. The Overall Assessment as an Epistemic Black Box

Humboldt University explicitly justified its diagnostic decision not on the basis of a single test, but through the integration of all information collected. The diagnostic report states:

> *"It should be emphasised that diagnostic classification is fundamentally not made on the basis of a single procedure. Assessment is always based on the integration of all information collected. Only this overall assessment makes a well-founded clinical judgement possible."*

This principle is initially professionally plausible. No single questionnaire, no informant history and no standardised observational procedure can carry a complex autism assessment alone. Different data sources must be connected with one another, contradictions contextualised and alternative explanations examined.

The problem with the procedure examined therefore did not lie in the fact that an overall assessment was undertaken.

It lay in the fact that the overall assessment was invoked as the decisive epistemic authority while its concrete functioning remained invisible.

The concept designated the centre of the decision and simultaneously its least reviewable part.

In this context, Meehl's (1954) foundational study *Clinical Versus Statistical Prediction* must also be considered. Meehl showed that the free clinical overall judgement of a professional is by no means automatically more reliable than a rule-based or statistical combination of the same information. Particularly where numerous individual findings are connected into a result only through undisclosed clinical weighting, no epistemic added value arises merely through invoking experience or intuition. Meehl's finding does not mean that standardised procedures could fully capture the individual case or replace clinical judgement. It does, however, call into question the assumption that an opaque "overall assessment" possesses greater validity merely because it was carried out by experienced diagnosticians. Where such an overall assessment departs substantially from converging psychometric, biographical and functional evidence, its rule of combination would therefore need to be transparently disclosed and justified.

Integration Is Not Mere Addition

A diagnostic overall assessment is not a simple addition of test scores. Different data do not have the same weight and do not measure the same thing.

A high AQ score must be assessed differently from a clinical observation. An informant history from the partner provides a different kind of access from an examination lasting a few hours. An ADOS score represents a standardised situation, while a thirty-year history of work production can reveal long-term patterns of attachment and functioning. Developmental data from childhood, in turn, concern a different temporal domain.

The task of the overall assessment is therefore not to place all information side by side and then formulate an overall impression. It must explain how heterogeneous evidence was related to one another.

This includes at least the following questions:

Which data support a hypothesis?

Which speak against it?

Which sources are independent of one another?

Which results might have been influenced by the same cause?

Which data possess great temporal depth, and which only situational validity?

Which explanation connects the largest number of findings with the fewest additional assumptions?

And at which points does uncertainty remain?

Only a traceable answer to these questions turns an accumulation of data into a scientifically testable integration.

In the present report, by contrast, the result of the overall assessment was communicated, not its epistemic path. And when individual elements of the report were objectively refuted without contradiction, what remained was only the reference to an overall assessment whose apparently

legitimate components could no longer be enumerated. If part of the foundation of an overall assessment is removed, the remainder must still be capable of supporting the overall assessment.

Given the substantial refutation and debate that occurred during the feedback meeting, the overall assessment stood under considerable pressure to justify itself.

The denial of a special interest is not a minor matter.

The Result Replaces the Derivation

The final assessment states:

> *"Against the background of the data collected, and taking into account the biographical course and current life situation, in the overall assessment of all findings we diagnose no presence of an autism spectrum disorder in adulthood according to ICD-10 and DSM-5."*

It further states:

> *"Overall, the findings speak against the presence of an autism spectrum disorder. The abnormalities identified cannot be brought together into a continuous pattern required for the diagnosis."*

These sentences name the judgement. They do not yet explain how it was reached.

The problem is that, on the one hand, these are extremely soft formulations ending in a concrete-like judgement, while on the other hand there was repeated reference to an overall impression that, from a purely methodological perspective, could only have been developed inadequately. ADOS was, in scientific terms, effectively unusable here as a method; the differential diagnosis dealt more with alternatives to autism than with autism itself; and apart from the strangely thin interview, very little remained when one compares these data alone with the density of data set out in Appendix 1. Appendix 1 contains more than 20 pages; the Humboldt report only four.

The claim that the abnormalities could not be connected into a continuous pattern is precisely the point that would require justification. Which abnormalities could not be connected? At what point did the pattern break apart? Which necessary continuity was missing? Which alternative explanation connected the data better?

The use of ICD-10 represented a massive restriction of the concept of autism in relation to the state of research. The problem surrounding the question of special interest fundamentally touched one pillar of the diagnostic criteria. If this had not been properly understood, then all the other relationships and assumptions were no longer correct either.

If one does not see the monotropic mode of thinking, one also misunderstands the social deficits. If one marginalises the social deficits because someone masks well, other factors are distorted as well.

It was therefore impossible to speak of an overall assessment when fundamental pillars were unstable.

Autism was excluded because no sufficient overall pattern emerged. But what if the methodology did not make this possible in any real sense, but merely failed to reach a pre-formulated expectation and that expectation was too simplified?

A circular justification thereby threatened.

For unlike the listed values of the individual assessments, the overall assessment itself possessed no evaluative pattern that was transparent in any way. This became problematic when objectively measurable errors by the clinic were substantiated and no correction of the overall assessment followed.

Nor was this possible because the diagnostician rejected the time required, as she expressed it, because the health insurer would not pay for it and she, as was already known, wanted to keep her job.

One has to imagine that people wait years for this assessment.

If the diagnostician viewed the patient exclusively through a template of ICD-10 and the autism derived from it, and did not continually ask whether autism might perhaps become visible here in a different form, this degraded diagnosis into a dinosaur that necessarily always lags behind research, with questionable epistemic legitimacy.

It appeared as though Humboldt simply did not take masking into account. Despite the high CAT-Q score, this was neither contextualised in the report nor addressed in any way when asked.

Here it became apparent that the clinic was, in legal terms, quite deliberately referring explicitly only to autism recognisable under ICD-10: *"...no presence of an autism spectrum disorder in adulthood according to ICD-10 and DSM-5."* But in 2026, particularly for a university clinic, it is completely unserious and irresponsible to act as though it were legitimate to exclude autism according to outdated standards. The standards were substantially changed for a reason. ICD-11 in particular would have improved the author's situation considerably.

The clinic also had a motive for remaining with ICD-10. It benefited from this for several reasons. It functioned like a useful filter, simplified the work and more easily excluded precisely those profiles that would be even more demanding to diagnose because of masking and other factors. This particularly affected weighting.

The Invisible Weighting Rule

In the author's case, substantial contradictions existed between the data sources.

The AQ, at 43, was clearly above the threshold stated in the report. The partner's SRS informant assessment was strongly elevated. Further screenings submitted likewise produced high scores. According to the documentation, the long-term psychotherapeutic professional from the author's circle affirmed autism. At the same time, the ADOS score lay below the cut-off and the clinic's clinical assessment denied sufficient abnormalities in the core domains. The report itself, however, explained that ADOS cut-offs can be missed in people with high cognitive ability and masking even when autism is present. Yet this was not related to the concrete case or even commented upon.

The author had shown that all symptoms required even under ICD-10 — impaired relationships, repetitive behaviour, special interest and communication problems — were indeed present, but because the clinic stated that it could not observe them in the questionable setting, they were erased.

Such a constellation requires an explicit weighting rule. But none was provided, or it was not made transparent.

Why was clinical observation weighted more heavily than several clearly elevated self-reports and informant reports? Including that of a psychotherapist.

What significance was assigned to the low ADOS score even though its limited power to exclude was acknowledged in the report itself? From a scientific perspective, in the author's specific profile — giftedness and older age — this should have been clearly labelled as questionable.

When all one hears is the word "overall assessment", a report of only four pages suddenly appears very fragile.

How, for example, were the high masking scores from the CAT-Q result taken into account?

What weight was assigned to the almost thirty-year attachment to the body of work?

How was the positive assessment, the professional statement of the long-term psychotherapeutic reference person, contextualised at all?

How were missing early-childhood documents handled?

And what evidence concretely spoke against repetitive and restricted interests?

The report did not answer these questions in a way that allowed the weighting to be externally examined.

This does not mean that no weighting took place internally. The clinic apparently possessed a rule, or at least a clinical practice, according to which it ordered the contradictory data.

This rule remained hidden, however, which becomes problematic at the latest when one asks what patients have a right to.

One may explain that this is clinical practice. But here was a patient active in autism research who had publicly announced that he would subsequently analyse the clinic's diagnostic procedure in another study. The clinic knew that the author possessed the competence to dissect every aspect of the weighting used by the clinic. From a scientific perspective, further extensive evidence could have been extracted from this. The clinic chose to obscure the evidence.

Furthermore, the overall assessment could under no circumstances function as a reference within a report if the weighting question could not be explained in the concrete case when asked. This violated fundamental ethical and scientific rules designed to prevent circularity.

A clinical report is not a consumer product in which a company can conceal defects through advertising. The procedure must be fully reviewable and traceable, which became particularly problematic when components of the overall assessment collapsed.

The question of ICD-10 or ICD-11 changed the weighting substantially.

Under **ICD-10**, simultaneous diagnosis of ADHD (hyperkinetic disorder) and Asperger syndrome was not provided for in the original WHO system. For years, this led clinics often to have to decide which

of the two was present. ICD-10 arose from a period in which autism was defined much more strongly through **observable behaviour**.

From around 2015–2025, the following increasingly became established internationally:

- masking;
- camouflaging;
- compensation;
- monotropism;
- Double Empathy

as central components of understanding autistic adults.

The actual bottleneck here appeared to be: ICD-10 + classical German Theory-of-Mind-oriented diagnosis + strong weighting of current social observation + limited consideration of masking and AuDHD. ICD-11 would have mitigated this substantially.

Overall Assessment as a Reserve of Authority

In the feedback meeting, the concept of the overall assessment acquired a particular function. Whenever the author disputed individual evaluations, according to his documentation the diagnosticians repeatedly referred to the overall picture.

The author disputed that no special interest was present.

The answer was the overall assessment.

He disputed that his social functioning had been adequately captured through the brief interaction.

The answer was the overall assessment.

He referred to high screening scores, masking, long-term evidence and the limitations of ADOS.

The decision remained in place because of the overall assessment.

The more strongly individual components of the judgement were challenged, the more the justification shifted to a level above those components.

The overall assessment thereby became a **reserve of authority**.

It could be deployed where no individual finding clearly carried the judgement. This is not automatically illegitimate. Particularly in complex cases, the overall picture may be more informative than individual results.

It becomes problematic, however, when the overall picture remains unchanged even after central components of its formation have been disputed.

An overall assessment must depend on its parts.

If it continues to exist independently of whether individual parts were misunderstood, inadequately collected, scientifically outdated or methodologically limited, it becomes an independent assertion.

It becomes gatekeeping.

And gatekeeping must under no circumstances be allowed to deny help to those affected.

The Whole Without Its Parts

The formula "The whole is more than the sum of its parts" can be diagnostically meaningful. A clinical gestalt arises from relationships between data, not merely from considering them in isolation.

But the whole cannot exist without its parts.

If the clinic assumed an absent special interest, this assumption had to make an identifiable contribution to the overall judgement. But what contribution? If it classified social abnormalities as insufficient, that too had to be justified. But how? If early-childhood data were missing, it had to be shown what diagnostic uncertainty arose from this and also which data specifically were missing.

Was there one sandbox experience too few, or why was the statement that the author had constantly been called a "little philosopher" and thereby humiliated insufficient? How often does a child have to be beaten in childhood in order to count as autistic?

Which assumptions were presupposed?

If one of these assumptions is corrected, the overall assessment must be capable of changing.

Otherwise it becomes unfalsifiable.

The judgement was already closed.

The overall assessment therefore no longer designated merely the formation of the finding. It protected the completed finding against subsequent reopening. It protected the institution from every criticism.

The Missing Evidence Architecture

A traceable overall assessment would have to disclose at least the basic structure of its evidence architecture.

For example:

Diagnostic Domain	Evidence For	Evidence Against	Limitations	Weighting
Social communication	Long-standing misunderstandings, social exhaustion, high AQ/SRS scores	Situationally good reciprocity in conversation, low ADOS range	Masking, high verbal competence, artificial setting	Reasoned overall judgement
Repetitive interests and attachments	Thirty-year attachment to the body of work, high intensity, severe difficulty interrupting, regulatory function	Topic culturally ordinary, few visibly stereotyped behaviours	Work material only partly examined	Reasoned overall judgement

Diagnostic Domain	Evidence For	Evidence Against	Limitations	Weighting
Developmental onset	Individual childhood memories and long-term continuity	Lack of comprehensive early informant history	Age of the person, missing sources	Remaining uncertainty
Alternative explanations	ADHD, exhaustion, social avoidance, personality traits	Lack of a coherent counter-model	Overlaps and possible secondary consequences	Reasoned overall judgement

Such a matrix would not have to decide the diagnosis mechanically. It would, however, make visible which data actually entered into the judgement and which uncertainties remained.

No such representation existed in the present report. There were similarly structured notes, but no concrete elaboration that could have been sufficiently examined for misunderstandings.

Instead, procedures were described, scores named, and an overall judgement then formulated.

The transition between the two remained the black box.

The Selectivity of the Claimed Integration

The clinic stated that the assessment was based on the integration of **all information collected**.

In the concrete case, this formulation raises an additional question: what counted as "collected information" at all?

It appears implausible that the approximately 1,000 pages of submitted data were actually collected in this sense.

Did this include only the interviews, tests and informant histories conducted by the clinic itself?

Or also the submitted books, papers, the film, the scientific statement, earlier screening scores and extensive biographical documents?

The materials had been submitted. They therefore formed part of the available data in a broader sense. Whether they also became part of the diagnostic overall assessment remained unclear.

RAADS-R and others were not mentioned in the report. They would also have shifted the weighting substantially. The clinic may decide to ignore prior screenings, which is questionable given the density of data associated with them. But it should not simply fail to mention them.

An important distinction becomes visible here between **available**, **acknowledged**, **examined** and **weighted** evidence.

A document can physically lie in the clinic without being read. It can be skimmed without being substantively examined. It can be read without being mentioned in the case conference. It can be mentioned but receive no recognisable weight.

The statement that all information had been integrated therefore says little unless it is clarified which stage of processing was actually reached. Particularly with unusually extensive long-term evidence, the clinic should have disclosed which materials it could not consider, or could consider only in excerpts.

Without such disclosure, an impression of completeness arises that the procedure apparently could not deliver.

If, in addition, there is a political motive and resource scarcity within a clinic, the overall assessment can in this way simply mean that the framework, the filter, was reduced so strongly that, as at Humboldt, only around 30% of presenting patients received an autism diagnosis.

The Overall Assessment as a Translation of Resources

It thereby becomes visible that the overall assessment possessed not only a professional but also an organisational function.

The clinic had to translate a very large quantity of heterogeneous information into a decision within limited time and limited resources. The case conference could not reconstruct the author's entire life. It required a manageable case gestalt.

Institutionally, this is unavoidable. But scientifically and ethically, it is questionable.

Because this manageability changes what can appear as diagnostic reality.

Material that is easily codable has an advantage:

- test scores;
- brief interview statements;
- observable behaviour;
- standardised categories;
- concise informant histories.

Material requiring longer engagement has a disadvantage:

- a body of work developed over decades;
- complex autobiographical connections;
- the person's own theoretical models;
- contradictory institutional experiences;
- the functional significance of an activity over long periods;
- and the costs of learned compensation.

The overall assessment is therefore not neutral towards the form of evidence. It privileges what the procedure can absorb.

This means:

> *The institution's capacity for integration co-determines which reality can enter the overall picture.*

If this selectivity is not made visible, the result appears as a complete assessment of the person, even though it is also a representation of the clinic's resource structure.

Precisely an overall assessment can therefore distort through pure complexity reduction.

From Resource Limitation to Truth

Here lies the transition to the later ethical problem.

Because of limited resources, a clinic cannot collect or examine every conceivable form of evidence. It may complete a procedure even though residual uncertainties remain.

It must, however, distinguish between two statements:

> *"We were unable to integrate these data sufficiently within our procedure."*

and:

> *"These data do not produce an autistic overall picture."*

The first statement names a limitation of the institution. The second describes a characteristic of the person being assessed.

If the transition between the two is not transparent, resource scarcity can be translated into diagnostic truth.

The procedure can process only a limited reality. The report subsequently declares this processed reality to be the overall picture.

Precisely through this, the overall assessment becomes an epistemic black box: inside it disappear not only data, but also the distinction between what was not available, what was not examined, what was not understood, and what actually spoke against the diagnosis.

The central question here is whether such a finding is scientifically robust at all. Whether it may create the impression of representing a truth. For this is not exploratory research into new territory in which mistakes may happen. Rather, evidential burden is consciously excluded from a procedure in order to produce simplified official documents as cheaply as possible, which are later used as evidence in court proceedings.

Yes, then one would have to ask whether autism assessment is realistically possible at all under these conditions. If it is not, as this investigation illuminates, then this has political and legal consequences that must be publicly articulated.

Such a clinic might then have to be closed.

It would then be a greater danger than a benefit.

Certainly, it might recognise some autistic people; it might overlook just as many. That is not an acceptable risk.

The Alternative Model as a Necessary Part of the Overall Assessment

A negative diagnosis requires more than the finding that criteria are not sufficiently fulfilled when, at the same time, a substantial and long-standing need for explanation remains.

The overall assessment would then have to do more than dismantle the rejected hypothesis. It would have to develop an alternative model that connects the available data at least equally well.

In the present report, ADHD, dysthymia and narcissistic personality traits were named. The elevated autism-related scores were associated with other psychological burdens and personality characteristics.

But it remained unclear how these categories together explained the following structure:

- attachment to the body of work lasting almost three decades;
- approximately full-time work despite lack of payment;
- limited ability to sustain other forms of work;
- massive problems with transitions and interruptions;
- social functioning problems despite situational verbal competence;
- high masking scores;
- recurrent exhaustion and decompensation;
- and the convergence of several autism-related instruments.

An alternative model must not merely distribute the phenomena across different diagnoses.

It must explain their connection.

Without such a counter-model, the overall assessment remains negative: it says why the autism hypothesis was not accepted, but not which structure instead holds the author's life together.

This is particularly fatal when it happens at the highest level of institutional diagnosis and there is then no adequate alternative place left to go in order to clarify what else might explain this profile. Under these conditions of resource reduction, this would lead to a chain of calculated misdiagnoses.

Something many autistic people report.

A Hierarchy of Explanatory Burden

Within the procedure, different hypotheses appeared to be subject to different burdens of justification.

The autism hypothesis had to show a complete, early-beginning and clearly evidenced pattern across the core domains.

The alternative categories, by contrast, could capture individual areas:

ADHD explained attention and organisation.

Dysthymia explained exhaustion and depressive burden.

Social anxiety explained avoidance.

Narcissistic personality traits explained self-reference, desire for recognition and possibly high self-assessment scores.

The autism hypothesis was thereby examined as an overall model, while the alternatives were admitted as partial models.

The overall assessment should, however, have treated both sides symmetrically.

If autism is rejected because it does not fully integrate the data, the alternative model must show that it integrates these data better. Otherwise, an asymmetrical examination arises:

The rejected model must explain everything.

The accepted models each only have to explain something.

This asymmetry is a substantial part of the black box.

It is scientifically dishonest.

Uncertainty Must Not Disappear in the Overall Judgement

Complex adult assessment does not always produce unequivocal results. There may be cases in which substantial characteristics are present while the developmental history remains incomplete. High screening scores may coexist with unremarkable clinical observation. Masking may be plausible but difficult to objectify. Comorbidities may obscure the picture.

In such cases, uncertainty is not failure. It is a scientifically legitimate result.

Possible formulations would be:

- Autism could not be confirmed with sufficient certainty.
- Autism cannot be reliably excluded because of the contradictory data.
- Assessability is limited because of missing developmental data and strong compensation.
- An independent second assessment is recommended.
- Autistic characteristics with clinically relevant impairment are present, without the formal criteria having been conclusively confirmed.

This is particularly explosive because Prof. Dziobek stated in the previously mentioned lecture that further examinations would be carried out in unclear cases, meaning additional appointments would be arranged. Why was that not done here? Well, there may have been an interest in getting rid of the author as quickly as possible. Naturally, this cannot be proven as a motive, but it remains a suspicion. In any event, the internal handling of a difficult case documented here not only contradicts the external and public presentation by Prof. Dziobek, which described sensitive handling of difficult cases, but shows the exact opposite.

The author was virtually sentenced to being non-autistic. Objection futile.

The present finding chose a clear negative overall statement. The findings supposedly spoke overall against autism. But on what basis? The author's material was not refuted. Appendix 1 was not refuted. Worse still: it was not mentioned with a single word.

Precisely in view of the documented contradictions, this unequivocal conclusion itself would have required justification.

The overall assessment may integrate uncertainty.

It must not simply destroy it.

The Black Box Protects More Than the Judgement

The lack of transparency simultaneously protects the institution against precise criticism.

This can also be seen in the effort required here.

As long as it is unknown which data were weighted in what way, an objection can easily miss the decision. If ADOS is criticised, the clinic can explain that the diagnosis did not rest on ADOS alone.

If the interviews are criticised, questionnaires and informant histories can be invoked. If the high questionnaire scores are mentioned, clinical observation and the overall assessment can be invoked. If attachment to the body of work is raised, it can be stated that individual interests are insufficient.

Every data source can be relativised as not decisive on its own. The decision supposedly lies in their connection.

Precisely this connection, however, remains invisible. When asked, the clinic could not provide it.

Criticism is thereby placed in a peculiar position: it can examine every visible component, but not the internal operation that transformed the components into the judgement. The overall assessment thus becomes not only an epistemic black box but also a black box of responsibility.

Because this practice is used not only at Humboldt but in autism assessments throughout the world, a massive question arises here concerning the danger of an unscientific distortion of the overall picture of what clinically counts as autism and what does not.

Given debates about overdiagnosis and underdiagnosis, this practice is highly relevant to the scientific question and urgently demands investigation.

Scientific Authority Without Replicability

A scientifically oriented diagnostic procedure does not have to be replicable in the narrow experimental sense. Clinical judgements contain experience, situational assessment and pattern recognition that cannot be completely formalised.

Nevertheless, an independent expert team should at least be able to understand, on the basis of the documented data, why the judgement was reached.

In the present case, a central question would be:

Would another specialised team, using the same interviews, questionnaires, informant histories, work materials and biographical data, be able to understand how Humboldt arrived at its exclusion?

The report provides too little information for this.

It names the procedures used and the result. But it does not sufficiently document which concrete observations carried the exclusion and how contradictory evidence was overcome.

The judgement is therefore institutionally authorised but only to a limited extent epistemically reconstructable.

Professional expertise resides inside the black box and is authenticated by the name of the institution.

The Diagnostic Evidence Matrix

A concrete reform demand can be derived from this case: in complex and contradictory adult assessments, a **diagnostic evidence matrix** should form part of the report, or at least of the internal documentation.

For each core domain, it should indicate:

1. What evidence supports it?
2. What evidence speaks against it?
3. From which source does the evidence originate?
4. What methodological limitations does the source have?
5. Which alternative explanation was examined?
6. How was the contradiction weighted?
7. What uncertainty remains?
8. What additional data would be required for a more certain decision?

Such a matrix would not replace clinical judgement with mathematics. But it would make visible the transitions at which professional interpretation takes place.

It would also prevent "overall assessment" from being used merely as a concluding formula.

The more complex and consequential the judgement, the greater the required depth of justification.

The Overall Assessment as an Ethical Site

The overall assessment is not merely a methodological site, but an ethical one.

Within it, decisions are made about which experiences are recognised as part of a legitimate pattern. It determines whether exhaustion is read as depression, social avoidance as anxiety, intense attachment to a body of work as occupation or special interest, and persistent self-advocacy as professional competence or narcissistic self-aggrandisement.

The overall assessment does not merely organise symptoms.

It organises the person morally and socially.

This effect becomes particularly powerful when the result is later used by courts, authorities and other treating professionals. The internal clinical interpretation then leaves the diagnostic room and becomes part of institutional reality.

The finding turns a non-transparent weighting into a publicly effective description of a person.

Precisely for this reason, the overall assessment must not be treated as a protected domain of professional intuition.

In the procedure examined, the overall assessment was presented as the highest form of clinical knowledge. It was supposed to compensate for the limitations of individual procedures and produce a well-founded judgement from contradictory data.

But precisely because it claimed this function, it should have been particularly transparent.

Instead, it remained unclear:

- which materials were actually included;
- which data were decisive;
- which weighting rule applied;
- how contradictions were resolved;
- which alternative model carried the overall biography;
- and why the remaining uncertainty permitted an unequivocal exclusion.

The overall assessment was therefore not empty. An internal process did take place. Diagnosticians spoke, evaluated material and made a decision.

But this process was not externally reviewable and was barely accessible to the patient himself.

The black box therefore does not designate the absence of a decision. It designates the absence of a traceable transition from evidence to decision.

This is a problem because an autism diagnosis is not incidental, but can determine an entire life. There must be no unresolved inconsistencies there, or those affected will continue searching for answers for the rest of their lives. Under extreme suffering.

Here there is not only a duty to diagnose, but also a duty to truth. If this cannot be guaranteed, one should not pretend otherwise.

The following chapter examines the four realities that fell apart within this transition. For the clinical overall assessment was not the only possible ordering of the data. Alongside it stood the author's lived reality, the state of scientific knowledge and the diagnostician's suggested private assessment. Only one of these realities, however, was given the power to become the official finding.

12. Four Realities and the Monopolisation of Diagnostic Reality

In the feedback meeting, a problem emerged that went beyond the question of individual test scores or diagnostic criteria. There were not simply different opinions about the same data. Rather, four divergent realities emerged, each based on a different form of knowledge and possessing a different degree of institutional effectiveness.

These four realities were:

1. the author's lived reality;
2. the scientific reality of autism research;
3. the diagnostician's private professional reality;
4. the clinical-institutional reality of the report.

It must be emphasised again and again that autism is a lifelong diagnosis. If the author did not receive this diagnosis over 53 years, failed massively in life as a consequence (Lost Generation), waited years for access to assessment, and had hardly any alternatives to Humboldt, then what Humboldt did across two assessment days becomes a decision of fate of considerable magnitude.

The inadequate quality of the procedure stood in an extreme disproportion to its impact. That such a decision can be limited by the resources of a health insurer raises massive ethical concerns.

The four different realities caused the authority of the clinic to collapse. It left the author with chaos and confusion and provided no answers whatsoever to decades of experience. Worse still. It took that experience away from him by force.

Clinical Rule-Binding and Personal Responsibility

According to the documentation, the diagnostician indicated in substance that she had to adhere to the clinical requirements. This rule-binding is part of professional practice. Professionals cannot arbitrarily deviate from criteria merely because a case appears unusual to them.

Invoking rules, however, does not eliminate personal responsibility.

Rules are interpreted. Data are weighted. Uncertainties are formulated or concealed. A report can be written categorically or cautiously. A second opinion can be recommended or not recommended. A person can be supported after a conflict-laden feedback meeting or discharged without sustainable follow-up care.

Even within narrow clinical requirements, room for action remains.

The statement "The rules require this result" therefore cannot carry the whole responsibility. It would have to show which rule actually required which concrete conclusion and which alternative professional responses remained possible.

In the present case, precisely this remained unclear.

The requirements appeared as an external necessity. The decision was thereby depersonalised. Nobody appeared to be fully the author of the result. The diagnostician may privately have had a different view.

The clinic followed the criteria. The finding emerged from the overall assessment. The classification defined the framework. Precisely in this distribution, responsibility can disappear.

Diffusion of Responsibility Between the Realities

The four realities produced a structure of diffusion of responsibility.

Science could say:

> *We do not know exactly what autism is; diagnoses must be made clinically.*

The clinic could say:

> *We adhere to the existing criteria and procedures.*

The diagnostician could say:

> *Privately, I may see some things differently, but clinically I am bound.*

The institution could say:

> *The result is a professional decision of the team.*

Later authorities could say:

> *We rely on the university report.*

Each level referred to another. In the end, the author possessed an effective negative finding without any single level having to assume full responsibility for its reach.

Science did not take responsibility for the individual case. The individual diagnostician did not take responsibility for the system. The institution did not take responsibility for the legal use of the report. The authority did not take responsibility for the diagnosis. The patient nevertheless bore all the consequences.

The Epistemic Burden Is Shifted Downwards

The contradictory realities were not resolved institutionally. Their tension was transferred to the author.

He had to process simultaneously:

- that his lived reality remained, for him, explainable through autism;
- that scientific research allowed for the possibility of a false-negative result;
- that the diagnostician may privately have thought differently;
- and that the official report nevertheless excluded autism.

The institution could keep these contradictions in separate sentences. The author had to bring them together within a single self-image. The epistemic burden was thereby shifted downwards. To the weakest point.

Ultimately, the author had to decide for himself whether to trust:

- his own perception of his life;
- the scientific literature;
- the diagnostician's implied doubts;
- or the official report.

Precisely this situation can lead to profound destabilisation. The person does not necessarily lose the capacity to think. They lose confidence in which source of knowledge they are still permitted to treat as legitimate.

Humboldt, in its own self-protection, completely withdrew from any responsibility for its own fallibility, which was obviously associated with an extremely high risk.

This hierarchy can be described as **institutional privileging of reality**.

It becomes a form of epistemic violence when an institution does not merely use its limited perspective, but delegitimises competing realities to such an extent that the person affected can barely trust their own experience anymore.

Epistemic violence here does not mean that every differing diagnosis is already violence. Professional disagreement is unavoidable.

It arises where:

- the institutional perspective does not disclose its own limitations;
- the perspective of the person affected is systematically devalued;
- the official judgement has far-reaching consequences;
- and there is no real possibility of placing the competing forms of knowledge into a reviewable relationship.

The question is therefore not merely:

> *Which reality was correct?*

It is:

> *Which reality was permitted to make mistakes without losing its authority?*

The author could be wrong and thereby be regarded as lacking insight, grandiose or diagnostically influenced. The clinic could be wrong and nevertheless retain institutional interpretive power.

It was therefore authorised to continue being wrong, meaning to accept these errors together with the associated health harms to those affected.

Clinical Reality Is Not the Whole Reality

The most important theoretical consequence of this chapter is:

> *A clinical finding is an institutionally produced reality, not the complete reality of the person being assessed.*

This does not mean that diagnoses are arbitrary or merely socially constructed. They are based on real characteristics, suffering, observations and scientific criteria.

But the finding emerges within a procedure:

- with limited time;
- limited instruments;
- limited capacity to absorb evidence;
- particular theories;
- institutional interests;
- and concrete communicative conditions.

Clinical reality is therefore neither unreal nor complete. It is an authorised partial reality. Precisely its authority obliges it to keep its own limitations visible.

Because its limitations may possibly be so severe that serious autism assessment is fundamentally impossible in real practice. That would be the admission of failure of an entire industry.

The Ethical Duty to Translate Between the Realities

Responsible diagnosis would have to attempt not to play the four realities against one another, but to translate between them.

It would have to ask:

How does clinical observation relate to long-term functioning in life? Which scientific limitations apply to the instruments used? Where does the professional have doubts? Which statements can be made with certainty, and which cannot? Which parts of the person's experience remain in need of explanation even after a negative result? What support does the person need irrespective of the categorical diagnosis?

Such a translation might, in the present case, still have led to a negative result. But it would have changed its meaning.

Instead of:

> *"There is no autism"*

the statement could, for example, have been:

> *"The formal criteria could not be confirmed with sufficient certainty within the present procedure despite substantial autistic characteristics and contradictory findings. Because of masking, limited developmental data and extensive long-term evidence that could not be fully integrated, however, autism cannot be reliably excluded."*

Such a finding would have named the clinical decision without destroying the other realities. It would have treated uncertainty not as weakness, but as scientific integrity.

It would, however, have had serious political consequences for healthcare provision. It would have made liability risks visible and forced a different judicial treatment of such reports.

Access to accommodations could then no longer depend on the report of a single clinic. The significance of the clinic itself would be called into question.

José Medina (2013) emphasises that epistemic injustice does not arise only through individual prejudice, but through social and institutional habits of perceiving, doubting and failing to perceive. Knowledge therefore requires a resistant sensitivity towards the blind spots of one's own position. Applied to diagnosis, this means: the clinical perspective must not confuse its limited visibility with the totality of reality. Precisely contradictory life evidence, informant evidence and self-evidence should become an occasion to examine the clinic's own diagnostic order of perception.

Monopolisation Becomes an Ethical Question

The monopolisation of diagnostic reality is particularly consequential because access to diagnosis itself was extremely scarce.

The author could not simply visit an equivalent independent centre the following day. After years and under statistically highly improbable conditions, the system had granted him a single access point. This gave the one decision an almost monopolistic position.

The clinic was not merely one voice among several. It was the rarely reached authority whose negative judgement could block further access to recognition and rights.

The scarcer the alternatives, the greater the ethical duty towards transparency, limitation and the possibility of correction.

A potentially fallible judgement is less dangerous when realistic second opinions are available. It becomes existential when it practically remains the only judgement.

According to the author's recollection, the diagnostician repeatedly indicated a differing private view. The report nevertheless stated that autism was not present.

Only this final sentence became institutionally mobile. The other realities did not disappear. They were merely rendered ineffective.

This is the core of the monopolisation of diagnostic reality:

> *It is not necessarily the reality with the greatest epistemic richness that prevails, but the one that can be institutionally signed.*

The following chapter turns to the temporal foundation of this production of reality. For the clinical reality rested substantially on a few hours of observable behaviour, while the opposing evidence came from a life course spanning decades. It is therefore necessary to examine how a diagnostic snapshot could obtain priority over the long-term functional history of an adult person.

13. The Disappeared Special Interest

Hardly any part of the diagnostic result was as surprising to the author as the finding that no sufficient special interest was present.

What must be examined is **how such a dominant and long-term documented life pattern could disappear within the diagnostic process.**

This concerned a core element of autism.

Special Interest Is Not a List of Topics

A first problem may lie in an overly narrow conception of what an autistic special interest is supposed to look like.

In everyday understanding, special interests are often associated with conspicuous, clearly bounded and culturally unusual subjects: timetables, technical systems, historical data, animal species, numbers or collections.

Such interests can occur. They do not, however, define the phenomenon.

What matters is not only **what** a person engages with.

What matters is **how** they are bound to it.

An autistic special interest therefore cannot reliably be recognised according to the social status of its subject matter. Art, philosophy, film, psychology or physics are initially ordinary cultural fields. They can be pursued as occupations, areas of study or leisure interests.

This does not exclude the possibility that the form of attachment is extraordinary.

Particularly relevant are:

- intensity;
- duration;
- repetitive return;
- temporal dominance;
- low interruptibility;
- priority over other activities;
- regulatory function;
- identity-forming effect;
- and functional costs in other areas of life.

The subject matter may be socially recognised.

The architecture of attachment may nevertheless be highly unusual.

In the author's case, the possible particularity therefore did not simply consist in his engagement with art and research. It lay in the fact that, for almost three decades, this activity bound the overwhelming majority of his available energy, attention and organisation of life.

As a consequence of neurodivergence, the author had also been unable to attend university. This was therefore not an ordinary professional career path, but rather the author spent his entire life engaged with a form of work that remained compelling and without alternative for him even when it impoverished him. This urgency forced him to become an autodidact.

From Special Interest to "Body of Work"

The social recognisability of the subject matter can even reduce its diagnostic readability.

A person who collects train numbers for decades quickly appears unusually focused. A person who produces books, films and theories for decades, by contrast, initially appears simply as an author, artist or researcher.

The behaviour becomes professionally or culturally readable.

The underlying form of attachment can thereby become invisible.

The author's body of work may therefore have acquired a kind of diagnostic camouflage. His endurance could appear as artistic ambition. The recurring themes could be read as a research focus. The inability to disengage from the work could count as commitment. The fact that almost his entire life was organised around it could be understood as a consciously chosen vocation. None of these readings is entirely implausible.

But they may capture only the socially accepted surface.

The decisive question would have been:

> *Why was the author able to continue this one form of work with extreme intensity over decades while other forms of work and life repeatedly failed?*

The body of work was not merely the content of his activity. It was the system within which functioning remained possible at all. It was a condition of his existence.

Success and Status Do Not Conceal an Attachment Structure

A special interest does not lose its diagnostic character merely because it produces high-quality or publicly receivable work. Otherwise, autistic interests would become diagnostically invisible precisely when they became culturally productive.

A child who engages obsessively with a topic may be recognised as unusual.

An adult who develops the same form of attachment into a body of work, a scientific career or a professional niche, by contrast, appears merely highly specialised. Similar problems are known in the diagnosis of women and girls. Their special interests are often not as exotic.

This creates a developmental paradox:

> *The successful transformation of a special interest into a socially readable activity can result in its autistic structure no longer being recognised later.*

Achievement replaces impairment in perception.

Yet both can exist simultaneously.

A special interest can:

- generate knowledge;
- enable professional competence;
- produce aesthetic or scientific contributions;
- secure self-regulation;
- and nevertheless displace other areas of life or make transition into ordinary forms of work more difficult.

Productivity does not refute the intensity of attachment. It can be its result.

The Wrong Question About Unusual Content

An overly narrow diagnostic procedure might implicitly ask:

> *Is the subject matter unusual enough?*

The more appropriate question would be:

> *Is the person's relationship to this subject matter unusually intense, enduring and life-determining?*

In the author's case, the subject matter was also less broad than labels such as "art and research" might initially suggest.

The body of work moved through different disciplines and media. Yet it repeatedly returned to particular structural problems: patterns in systems, differences in world-formation, institutional structures, perception, work, time, social violence and the translation of similar formal relationships between different domains.

The thematic surface changed. The underlying formal question remained stable.

This cross-domain recurrence may appear from the outside like great thematic breadth. Morphologically, by contrast, it may represent an extraordinarily narrow attachment to a single fundamental structural problem.

The author did not engage randomly with many subjects. He pursued one pattern through many subjects.

Precisely this form of concentration can be difficult to recognise in an ordinary interview when the diagnostician is primarily looking for a clearly nameable, isolated field of interest.

But the author had repeatedly and unsuccessfully tried to explain exactly this to the diagnosticians.

Repetition at a Higher Level

The finding that there were no sufficient repetitive behaviours raises a similar question.

Repetition does not have to appear only as directly visible motor or everyday repetition. It can also manifest in the long-term organisation of attention and knowledge.

Recurring operations existed within the author's body of work:

- the same structural questions were transferred into new domains;
- social, physical, psychological and aesthetic systems were examined for recurring formal relationships;
- earlier concepts were taken up again, shifted and integrated into new contexts;
- conflicts were documented and theoretically reconnected;
- and over years the body of work generated a recursive structure of references.

This does not mean that theoretical repetition automatically constitutes diagnostically relevant repetitive behaviour. It does mean, however, that repetition can occur on different levels.

A procedure that primarily looks for visible routines, movements or narrowly bounded activities may overlook higher-order structural repetition. The repetition may not have consisted in looking at exactly the same object every day. It may have consisted in processing the world again and again through the same fundamental formal question.

The author's body of work is known precisely for this. See his extensive research corpus:

https://zenodo.org/communities/operatoric-research-corpus-archive

The Biographical Totality of the Attachment

An ordinary interest usually has boundaries.

It is pursued after work, interrupted for other tasks or abandoned when life circumstances change. It can be meaningful without determining the entire organisation of life.

In the author's case, these boundaries were substantially weaker.

The attachment to the body of work endured:

- unemployment;
- poverty;
- lack of institutional recognition;
- limited financial reward;
- health crises;
- family burdens;
- legal conflicts;
- threats of homelessness and state sanctions;
- and repeated social rejection.

The activity was not abandoned even though for long periods it produced hardly any of the external rewards through which ordinary occupational motivation might be explained.

Precisely this is theoretically relevant.

An activity motivated primarily by career, income or recognition should, after decades without such rewards, at least lose a substantial degree of its binding force.

The body of work nevertheless remained. For 30 years.

It continued even under conditions in which it would have been rationally obvious to redirect the energy towards other activities.

The author did not do so.

According to his own account, he could not.

"He Did Not Want To" or "He Could Not Do Otherwise"?

Here, the question of special interest directly touches the assessment of the employment biography.

From the outside, concentration on one's own body of work can appear as a free choice of priorities:

> *The author preferred to work on his art and research rather than carry out other activities.*

According to his own account, however, a different structure emerged:

> *He could function sustainably only within this specific work; externally structured activities led to loss of functioning, overload or abandonment.*

The difference between **wanting** and **being able** is diagnostically and socially legally decisive.

If the attachment to the body of work is read as a conscious life choice, unemployment appears as a consequence of wrong priorities. If it is understood as a highly restricted condition of functioning, the same biography may indicate substantial impairment in flexible work capacity.

The special interest would then not merely be a preferred activity. It would simultaneously be the boundary of that to which capacity for action remained tied.

Precisely here, the clinic stripped his field of work of the entire aspect of the massive disability contained within it.

Regulation Rather Than Mere Enthusiasm

The author repeatedly explained that the work gave him energy and that his level of functioning declined when it was interrupted. The attachment to the body of work therefore had a regulatory function.

This function distinguishes a possible special interest from mere enthusiasm.

Many people enjoy working on things that interest them. They feel more motivated when they can use their strengths.

In the present case, however, a stronger dependence was described:

- The work stabilised concentration and thinking.
- It provided an ordered context.
- It reduced the burden of external demands.
- It maintained capacity for action.
- Its loss led not merely to boredom, but to recognisable destabilisation.

The interest may therefore not merely have been an object of attention.

It was a regulatory system.

The Costs of the Interest

Autistic special interests are frequently described positively: as sources of joy, competence, identity and self-regulation.

This positive function is real.

It must not, however, be separated from its possible costs.

In the author's case, the intensive production of the body of work was accompanied by substantial losses:

- hardly any regular integration into employment;
- chronic poverty;
- lack of social security;
- difficulty sustaining alternative activities;
- conflicts with institutions;
- and an extreme dependence on being able to continue his own work under self-determined conditions.

The work was simultaneously a resource and a limitation. It enabled extraordinary productivity. At the same time, it narrowed the possibilities for using this productivity within ordinary social and economic structures. Precisely this simultaneity would have been diagnostically informative.

An interest that exclusively produces joy and professional success has a different significance from an attachment that simultaneously organises survival and practically blocks other life paths.

Twenty-seven years of extensive unemployment combined with highly disciplined work over decades could be explained neither by ADHD, social phobia, dysthymia nor narcissism.

Here it became clear that ADHD could not explain this because the body of work did not follow a pattern of short-term dopamine seeking with a tendency towards distraction, but rather daily routine, massive perseverance and detail-driven precision. The drive was not dopamine, but pattern recognition.

A diagnostic procedure that asks only about enthusiasm, depth of knowledge or unusually long engagement can overlook this function.

It was grossly negligent that Humboldt did not investigate these relationships more closely despite the 27 years of unemployment, which painted an entirely different picture from crises triggered by ADHD. The hyperfocus here was not characterised by excitement, but by engagement with rather boring subjects over decades, as the psychotherapist friend had also emphasised. The author's body of work, amounting to 3,000–4,000 pages of published work, should have massively bored someone with ADHD alone. The picture simply did not fit together.

Why the Attachment to the Body of Work Could Disappear in the Interview

The case shows several possible mechanisms through which the special interest could fall out of the diagnostic picture.

First, the subject matter was culturally recognised. Art and research did not appear stereotypically unusual. Second, the activity was thematically broad. The underlying structural repetition could therefore appear as versatile interest. Third, the body of work was productive. Achievement could conceal the compulsive or binding character. Fourth, the explanation was complex. To understand the unity of the body of work, at least parts of the books and papers would have had to be examined substantively.

There should at least have been a minimal engagement with the publicly known body of work.

Fifth, little time was available for the interviews. A work structure spanning almost thirty years had to be condensed into a few sentences. Sixth, the author's repeated insistence on the significance of his body of work may already have been read under the hypothesis of self-overestimation or narcissism.

Seventh, according to the author's recollection, the younger diagnostician on whose notes the assessment apparently substantially relied was dealing with childhood and life history within a narrow time frame.

Each of these factors can contribute to the form of attachment not appearing as a diagnostic pattern.

Together, they produce a strong selection effect.

The procedure saw the occupational title, the publications and the self-presentation. It may not have seen the lifelong narrowing that lay beneath them.

And afterwards, the clinic also refused to see it.

The Problem of Unread Evidence

The assessment of the special interest depended particularly strongly on the material submitted. The mere statement "I have been working on a body of work for thirty years" could be exaggerated, idealised or retrospectively ordered. The body of work itself, however, could be examined. It was

publicly accessible, dated, published and documented in its development. It could at least have been examined on a sample basis:

- Do the same structural motifs actually recur?
- Is there extraordinary continuity?
- Do the works recursively refer to one another?
- Can the claimed attachment be objectified over decades?
- What role does the body of work play in the life course?
- Is it more an expression of flexible career work or of a strongly narrowed attachment to a subject?

Precisely here, the case possessed a rare form of external verifiability. Many people can describe their decades-long inner interests only retrospectively. The author could present a material corpus.

If this corpus was not substantively examined, the clinic could hardly reject the claimed structure on a well-founded basis. At most, it could establish that it had not been sufficiently captured within the interview. But lack of examination does not imply absence of a special interest.

The Unequal Treatment of Evidence and Assertion

The autism hypothesis was rejected on the grounds that the necessary patterns were not sufficiently demonstrated. At the same time, the opposite finding — no relevant special interest — was apparently made without the most extensive available evidence having been fully examined.

This created an asymmetrical evidential requirement:

The author was expected to prove the diagnostic significance of his attachment to the body of work. The clinic did not visibly have to prove why this attachment did not fulfil the criteria. Institutional non-recognition appeared as the default position. Recognition had to be fought for.

With a materially documented life structure spanning almost thirty years, however, the rejection itself would also have required explanation.

Which characteristic was missing?

Was the intensity not high enough?

Was the duration not long enough?

Was the narrowing not pronounced enough?

Was the regulatory function not plausible?

Were the functional costs not substantial?

Or was the subject matter simply too socially understandable to be perceived as a special interest?

The report did not make this transparent.

The Competition Between Two Readings

The body of work could fundamentally be read in at least two ways.

In an autistic reading, it showed:

- monotropism;
- extreme object attachment;
- long-term repetitive structural work;
- regulation through an internally generated system;
- limited transferability of work capacity;
- and a form of engagement with the world that remained stable over decades.

In a narcissistic reading, the same material could appear as:

- excessive self-reference;
- a grandiose claim to significance;
- a strong need for recognition;
- public self-presentation;
- and overvalued assessment of one's own research.

The data did not change.

Their meaning depended on the theoretical framework.

Precisely for this reason, both models would have needed to be examined.

Which model better explained:

- decades of work without significant recognition;
- persistence despite poverty;
- the regulatory effect;
- the limited flexibility;
- the repetitive return to the same structural problems;
- and the health consequences of interruption and external control?

The narcissistic reading could explain certain forms of self-presentation. It did not readily explain the attachment architecture of the body of work. The autistic reading may have captured this architecture better. The report did not show that this model comparison had been carried out systematically.

The Status Conflict as a Diagnostic Filter

The attachment to the body of work also encountered a conflict of social status.

At first glance, the author did not enter the clinic as a professor, established scientist or institutionally recognised artist. He had been unemployed for many years, was impoverished and published partly through self-publishing. On closer examination, however, one would also have recognised that he was invited to panel discussions, spoke at conferences, and had even once sat together with a Nobel Prize winner and other celebrities at the world's largest round table (*Dropping Knowledge*) to answer the

supposedly 100 most important questions facing humanity. He received public arts funding, was recognised as a freelance artist and published on PhilPapers. That was not nothing.

For a clinic that saw only the *Bürgergeld* recipient, however, the social authorisation that ordinarily legitimises extreme work attachment was missing. A professor who has worked on the same theory for thirty years can be regarded as specialised. An impoverished unemployed person who claims the same risks being perceived as unrealistic or self-aggrandising. Even though human history contains a great many examples of important contributions with precisely such profiles of poverty.

The diagnostic readability of the activity may therefore have depended not only on its content, but also on the status of its bearer.

This creates a risk of classist distortion.

Institutional success can normalise extreme focus. Institutional exclusion can pathologise the same focus. In the author's case, both occurred paradoxically at the same time: the attachment to the body of work was not recognised as an autistic special interest, but could serve as material for a narcissistic accentuation.

It was diagnostically too ordinary to be autistic. And simultaneously too self-referential to be merely ordinary work.

At the same time, the narcissistic hypothesis in relation to the body of work was not investigated further in light of the contradictions that had been exposed.

The Recoding of the Special Interest

A central mechanism thereby becomes visible.

The special interest did not disappear because the underlying data completely disappeared. The work, the books, the intensity and the insistence remained visible. But they were coded differently.

Attachment became ambition. Monotropism became self-reference.

The necessity of repeatedly referring to the body of work may have become a need for recognition.

The attempt to preserve the diagnostic relevance of the material became self-aggrandisement. The possible autistic feature was not erased. It changed explanatory systems.

Precisely therein lies the connection to the later chapter on moral recoding. The institution continued to see the same person and the same actions. It changed their diagnostic and moral meaning.

The Body of Work as Non-Integrable Evidence

The perhaps most fundamental reason for the disappearance, however, lay in the structure of the procedure itself.

The body of work was too large, too long, too interdisciplinary and too non-standardised to be processed easily within a few clinical appointments. It did not fit into a box.

It could not be reduced to a single test score. It required qualitative long-term analysis. It may therefore have been less usable for the diagnostic process than a brief answer to a standardised question.

The institution's difficulty in absorbing the material could subsequently appear as lack of diagnostic relevance.

The body of work was then not weak because it showed little. It was weak because the procedure possessed too little capacity to read what it showed.

Here, the central reversal of the entire case is repeated:

> *The limit of institutional capacity to absorb evidence was declared to be the limit of the evidence itself.*
>
> *For external observers who knew or know the author's internationally and openly accessible body of work, the entire process probably appears like a grotesque piece of theatre. That the author is highly likely to be autistic, that all kinds of people now also see him this way, and that his body of work can hardly be explained otherwise, shows how far realities can diverge and how difficult it can sometimes be to transmit facts through institutional filters. This demonstrates a massive problem in autism assessment, with an almost comic component.*

The Disappeared Special Interest as a Model Case

Many adults diagnosed late do not have special interests that appear childlike or stereotypical. Their intense attachment may have transformed in adult life into:

- professional expertise;
- scientific research;
- political work;
- art;
- therapeutic activity;
- activism;
- collecting and archival work;
- or a highly specialised private knowledge practice.

The more socially productive and linguistically reflective this attachment becomes, the more easily its autistic character can be overlooked.

The diagnostic process may then look for a visible special interest while the person has already built their entire life around that interest.

The niche is seen.

The necessity of the niche remains invisible.

The Ethical Significance of the Disappearance

For the author, the rejection of a special interest was not merely the rejection of a diagnostic criterion.

It concerned the central organisational form of his life.

The clinic was effectively telling him that the structure connecting work, poverty, regulation, identity and decades-long continuity did not diagnostically exist in the form he described.

A particularly deep form of epistemic injury thereby emerged.

It was not merely that individual symptoms were assessed differently. The connection through which the author had for the first time been able to understand his life was dissolved.

What remained were individual categories:

- unemployment;
- exhaustion;
- ADHD;
- social anxiety;
- personality traits;
- artistic work.

What disappeared was their common structure of attachment.

One must ask what right the clinic possessed to do this when the data it provided were by no means certain, indeed could not be certain.

How Strongly Should Special Interests Be Weighted at All?

The present case study simultaneously touches on a fundamental theoretical question in current autism research. For decades, classical diagnosis weighted primarily externally observable social deficits. More recent research approaches concerning monotropism, masking and Double Empathy, by contrast, foreground the possibility that the actual particularity of autistic cognition may lie less in a primary social deficit than in a specific organisation of attention, interest attachment and information processing. Social abnormalities would then, at least in part, be secondary consequences of this differently structured relationship to the world. From this perspective, long-term stable special interests and monotropic attachment to a body of work might under certain circumstances be more fundamental to understanding autistic cognition than situational observation of social reciprocity. Whether this is the case remains a subject of current research. The documented case nevertheless illustrates the diagnostic consequences that arise when the focus lies almost exclusively on external observation of social interaction.

If monotropism is in fact closer to the core than social deficits, then a diagnostic procedure that primarily assesses social performance would be systematically distorted.

In this context, the theory of **Hyper-Systemizing** (Baron-Cohen) is also significant. It understands autism not primarily as a deficit of social abilities, but as an exceptionally pronounced tendency to recognise, analyse and work on regularities, structures, laws and formal systems over long periods of time. Even though this theory remains controversial and does not fully explain the phenomenon of autism, it points towards an important diagnostic shift: the core of autistic cognition may lie less in

observable social deficits than in a specific form of opening up the world. Particularly in conjunction with newer approaches such as monotropism, masking and the Double Empathy Problem, this raises the question of whether exceptionally stable attachments to a body of work, long-term special interests and systemising modes of thought should receive greater diagnostic consideration than they have until now. The present case suggests that a diagnostic procedure primarily assessing externally observable social interaction risks underestimating precisely those cognitive organisational forms that may lie closer to the core of autistic information processing.

Remarkably, Hyper-Systemizing and monotropism do not necessarily contradict one another. While Hyper-Systemizing describes **what** is preferentially processed — namely systems, rules and structures — monotropism describes more **how** attention is organised: through an exceptionally strong and enduring attachment to a small number of information fields. Both approaches shift the diagnostic focus away from primarily social external observation towards the internal organisational principles of autistic cognition.

Research and Diagnosis: The Discrepancy Within the Same Institutional Environment

It is particularly remarkable that this criticism does not merely have to be brought to the Humboldt clinic from outside. A 2026 study by Mareike Bayer and Isabel Dziobek explicitly examines the functions, benefits and burdens of autistic special interests. The authors describe special interests as a highly prevalent feature of autism and simultaneously point out that, in research and clinical consideration, they were for a long time understood predominantly in deficit-oriented terms. Their own findings, by contrast, show that special interests have greater significance for autistic adults than for non-autistic comparison participants, particularly in emotion regulation and as a source of learning and knowledge (Bayer & Dziobek, 2026).

Quantitatively, the finding is also remarkable. The autistic participants in the study reported spending an average of 28.6 hours per week on their interests, compared with 14.2 hours in the non-autistic comparison group. This difference remained even when employment status was taken into account. Particularly in negative and exhausting situations, autistic people relied more often on their interests and less often on social strategies. Bayer and Dziobek accordingly explicitly interpret special interests as a possible adaptive resource for coping with stress and regulating emotions.

This produces, in the present case, a striking discrepancy between the scientific state of knowledge and diagnostic practice within the same institutional environment. The author had described an attachment to a body of work extending over almost three decades, in part comparable to full-time work, which simultaneously served regulation, knowledge production, stabilisation and maintenance of his functioning. Precisely those dimensions that Bayer and Dziobek scientifically identify as particularly relevant to autistic special interests were therefore biographically documented here to an extraordinary degree. Yet the diagnostic finding does not make it traceable that this structure received corresponding weight within the final overall assessment.

This discrepancy proves neither that the diagnostic decision was wrong nor that the findings of the later-published study could already have been transferred in identical form to the concrete case. It does,

however, create a substantial scientific need for explanation: **How can an institutional research environment empirically identify the regulatory, knowledge-forming and life-organising significance of autistic special interests while, within its own diagnostic practice, an extraordinarily pronounced combination of precisely these characteristics apparently receives no comparable epistemic weight?** The problem would then not necessarily be lack of knowledge about special interests, but the failure to translate this knowledge into diagnostic epistemic practice.

There is an additional difficulty in the philosophy of science. The autistic group in Bayer and Dziobek consisted of already diagnosed people; 85 percent reported receiving their diagnosis from a specialised clinic. The research therefore examines characteristics of those people whom the diagnostic selection system has already recognised as autistic. Persons whose monotropic or special-interest-shaped organisation of life is precisely not read as sufficiently autistic within the diagnostic process can, by contrast, fall out of such a research population. The question of the disappeared special interest therefore connects directly with the production of diagnostic populations examined later in this study.

The present case therefore leads to a broader question: Does a strongly socially focused autism assessment actually assess autism in its entire cognitive and biographical structure — or primarily the visibility of certain forms of social abnormality? If special interests, monotropism and long-term attentional attachment lie substantially closer to the internal organisation of autistic cognition than a primarily social-deficit-oriented external observation can capture, then the disappearance of an extraordinarily pronounced special interest from the diagnostic overall assessment would not be a minor detail. It could indicate a more fundamental limitation of the diagnostic model.

The Decisive Research Question

The central question of this chapter is therefore:

> *How intense, enduring, repetitive, regulatory and life-determining does an attachment still have to become before it is recognised by a diagnostic procedure as a possible special interest?*

If almost three decades of approximately full-time, largely unpaid, difficult-to-interrupt work organising all areas of life are not sufficient, the institution must explain what additional characteristic was supposed to have been missing.

The author, who could barely comprehend this, shouted at the diagnostician:

> *"But you cannot simply ignore a textbook example of a special interest without comment."*

According to his recollection, the diagnostician smiled arrogantly, let the author run into a wall and said nothing about it. Nothing at all. As though the author had spoken of something completely absurd.

Without this explanation, not only the concrete finding remains unclear. The suspicion of a systematic blind spot arises:

> *Adult special interests become diagnostically invisible where they have become culturally productive, theoretically complex or socially readable.*

The actual theoretical controversy today no longer concerns only the question of whether special interests are diagnostically relevant, but what position they occupy within autism itself. For decades, classical diagnosis understood autism primarily as a disorder of social communication and interaction. More recent research approaches concerning monotropism, Hyper-Systemizing, Double Empathy, masking and neurodivergent information processing increasingly shift the focus towards the internal organisation of attention, interest attachment and ways of opening up the world. From this perspective, social difficulties appear at least partly as a consequence of differently structured cognition and not necessarily as its actual origin.

This theoretical shift has substantial diagnostic consequences. If autism is defined primarily through observable social interaction, precisely those long-term organisational forms of attention, attachment to a body of work and cognitive specialisation that may lie closer to the actual core of autistic cognition fall out of view. A diagnostic procedure can thereby overlook precisely those people whose social performance appears relatively unremarkable because of decades of compensation, while their monotropic attachment structure is extraordinarily pronounced.

The following chapter examines what happened to the phenomena that remained after the autistic overall model had been rejected. They did not disappear. They were distributed across ADHD, dysthymia, social anxiety and narcissistic personality traits. It must therefore be examined whether this actually produced a superior alternative model or whether the need for explanation was merely fragmented.

14. From Comorbidity to the Fragmentation of the Need for Explanation

After the autism hypothesis had been rejected, the previously identified abnormalities did not disappear. The high screening scores, social exhaustion, long-standing employment difficulties, problems with transitions and external control, intense attachment to the body of work, depressive states and institutional conflicts all remained in need of explanation.

They were no longer treated, however, as parts of a possible common structure.

Instead, they were distributed across several diagnostic and psychological categories:

- ADHD;
- dysthymia;
- social anxiety or social avoidance;
- current reactions to burden;
- and narcissistic personality traits.

These categories may be justified in individual cases. ADHD had already been diagnosed previously. Chronic depressive states can genuinely exist. Social anxiety can occur independently or comorbidly. Personality traits may likewise legitimately be examined.

The problem therefore does not lie in the mere existence of several diagnoses.

It lies in the question of whether they produced a **superior explanatory model** or whether the connection between the phenomena was merely dissolved.

The decisive distinction is:

> *Distributing several phenomena across several categories is not the same as explaining their common structure of emergence and functioning.*

Comorbidity Is Not an Argument Against Autism

Autism does not occur in a diagnostically empty space. ADHD, anxiety disorders, depressive illnesses, states of exhaustion and traumatic burdens can exist simultaneously. They can reinforce one another, obscure one another or alter their visible presentation.

The presence of such a burden therefore does not automatically answer the question of whether autism is additionally present.

A person can be autistic and depressed. They can be autistic and develop social anxiety. They can have both ADHD and autism.

As a consequence of chronic overload, they can develop symptoms that later appear as an independent affective or personality-related disorder.

The differential-diagnostic task is therefore not to find some alternative category for every phenomenon. It must examine whether the alternative category explains the respective characteristic **more completely, more plausibly over time and more parsimoniously in structural terms** than the autism hypothesis.

Possibility is not explanation.

Fragmentation of the Need for Explanation

The mechanism observable here can be described as **fragmentation of the need for explanation**. A unified model is rejected. The connection it captured does not, however, disappear. It is broken down into smaller clinical units, each of which takes over a limited part.

Social exhaustion becomes depressive. Avoidance becomes anxiety-related. Organisational instability becomes ADHD. The attachment to the body of work becomes occupational or narcissistic self-reference. Conflicts become personality-related. The entire life is distributed across several categories.

Each individual attribution can appear superficially plausible. Only in the overall view does it become apparent that no single category, nor their mere addition, fully replaces the original structure.

Fragmentation possesses an institutional advantage.

A complex and difficult-to-capture overall model is translated into familiar, clinically manageable categories. These categories are diagnostically available. They can be coded, treated and represented in short reports. The question of whether together they form a convincing theory of the case recedes into the background.

This is already extensively recognised in autism research and also explains why many autistic people are mislabelled for decades with precisely these diagnoses, particularly personality disorder.

The clinic, especially Prof. Dziobek, should have recognised this problem, but apparently did not take sufficient precautions to prevent this danger.

ADHD as a Universal Residual Category

The already diagnosed ADHD provided a particularly available alternative explanation in the case examined.

ADHD can capture numerous phenomena:

- concentration difficulties;
- organisational problems;
- emotional dysregulation;
- impulsivity;
- fluctuating attention;
- hyperfocus;
- problems with routines;
- and social difficulties.

Precisely this breadth makes ADHD a plausible but also dangerously flexible residual category.

If a characteristic can fit both ADHD and autism, it must be examined more precisely how it is functionally organised. Humboldt negligently failed to do this.

Hyperfocus in ADHD can be variable, reward-dependent and activated by novelty. An autistic attachment to an object may be characterised more strongly by long-term stability, deep structural integration, low detachability and regulatory necessity.

The two forms can overlap.

Precisely in a possible AuDHD constellation, the task is not to assign every characteristic either to ADHD or to autism. It must be examined how both structures interlock.

In the author's case, ADHD could explain parts of attention and organisation. It did not readily explain why a single structure of work remained stable for almost three decades while other forms of work failed.

A model using ADHD as an explanation must account precisely for this unusual stability.

According to the statement of the Wissenschaftliche Gesellschaft Autismus-Spektrum on ICD-11, the newer classification logic requires, particularly in the overlap between ADHD and autism, a comorbidity-open, heterogeneity-sensitive and carefully differential-diagnostically justified assessment. By contrast, the Humboldt clinic formally assessed the author on the basis of ICD-10. The WGAS emphasises that comorbidity between autism and ADHD is explicitly permitted under ICD-11. It writes:

> *"The grouping of autistic disorders among the 'neurodevelopmental disorders' was undertaken because all of the disorders named frequently occur together and share many characteristics."*

At the same time, it emphasises the "enormous heterogeneity" of the autism spectrum.

This creates a fundamental problem for assessment in 2026 that may formally still code according to ICD-10 while reproducing in substantive interpretation an opposition between ADHD and autism that has since become outdated. The question could not be whether autism-related findings might possibly also occur in ADHD. Rather, it should have been examined whether ADHD actually explained the entire profile sufficiently or whether both neurodevelopmental structures were present together. Formal use of ICD-10 did not release the clinic from the obligation to take into account the current state of research, the recognised comorbidity and the heterogeneity of autistic presentations. Beyond the immediate statements of the position paper, this also concerns more recent findings on compensation and masking.

An exclusion that rests substantially on reciprocity observed during a few assessment situations, comparison with a clinically preselected autistic population, and a blanket attribution of autism-related findings to ADHD or personality traits does not distinguish the possible explanations from one another in a traceable way. Rather, it conflates them by using the co-occurrence and substantive overlap of the conditions as an argument against, instead of as a reason for, a more differentiated comorbidity assessment.

The WGAS demands:

> *"From the perspective of the WGAS, it must be required, when diagnosing according to ICD-11, to justify in detail why the symptomatology cannot be explained by one or more of the differential diagnoses named."*

This requirement relates directly to assigning an autism diagnosis. Methodologically, however, it must also apply in the opposite direction: if alternative diagnoses are invoked to explain an extensive autism-related profile, it must be traceable in detail which findings are explained by which alternative, why that explanation fits the overall profile better, and why comorbidity is excluded. The Humboldt clinic's report does not provide such a detailed resolution. Formal application of ICD-10 does not eliminate this deficit of justification.

Prof. Dziobek herself is a member of the WGAS.

The Diagnostic Arrow of Time

Distinguishing between primary structure and secondary disorder requires temporal analysis.

What was present first?

Which difficulties existed before depressive crises? Which social patterns were present before the supposedly absent severe anxiety arose? Which work and attachment forms remained stable over decades? Which symptoms intensified only after institutional violence, poverty and repeated failure?

Without this diagnostic arrow of time, later consequences can retrospectively be declared causes.

An adult person appears depressed, socially anxious, exhausted and conflict-laden. From this it is concluded that these categories explain their self-assessment as autistic.

But another possibility is:

> *Autism that remained unrecognised and unsupported for decades contributed to the development of precisely the depression, anxiety and conflict-laden behaviour that were later used against the autism hypothesis.*

This creates a circular exclusion mechanism. The consequences of remaining unrecognised become evidence of non-existence.

This is particularly serious because what the author experienced belongs to everyday practice at many clinics. We do not know how many autistic people have been misdiagnosed, not recognised, or conversely labelled as neurodivergent in this way even though other causes were present. What is clear is that the method used by the clinic does not appear to provide adequate safeguards even remotely capable of preventing this danger.

Comorbidity as Diagnostic Fog

The more burdens are present in adulthood, the more difficult diagnosis becomes.

Trauma, depression, anxiety, ADHD, chronic exhaustion and personality changes can overlay the presentation. A simple profile can then no longer be expected.

Precisely this, however, must not lead to autism being excluded because the picture appears too complex.

Complexity can not only speak against a diagnosis. It can be the result of decades of overlay.

The adult patient does not necessarily bring a "pure" autism into the clinic. Quite apart from the fact that research does not know such a thing either.

They bring a life with:

- adaptation;
- failure;
- protective strategies;
- misdiagnoses;
- traumatisation;
- social selection processes;
- and secondary disorders.

A diagnostic procedure that searches for a clear autism profile untouched by these consequences can miss precisely those people who have had to live the longest without recognition. Here too, it becomes highly problematic that ICD-10 rather than ICD-11 formed the basis. This further intensifies the problem when deliberate improvements arising from research and the WHO are not adopted promptly by clinics.

The Problem of the Clinically Familiar Model

Fragmented alternative explanations possess another advantage: they are clinically familiar.

ADHD, depression, anxiety and narcissistic personality traits are established categories for which typical interview questions, treatment pathways and interpretive patterns exist. A complex autistic adult profile with high verbal competence, decades of masking, unusual attachment to a body of work and a history of institutional conflict, by contrast, requires a more elaborate reconstruction.

The diagnosis is therefore not selected solely according to explanatory quality.

It can also be influenced by which model is easier to handle within the available procedure.

The clinically familiar model requires less translation work. The unusual model generates more uncertainty.

Under resource scarcity, this difference can become decisive. It is not necessarily the most plausible model that prevails. It may be the one that best fits the existing diagnostic infrastructure.

Treatment as a Test of the Explanatory Model

A diagnostic model should also be measured by what treatment or support follows from it.

The clinic's alternative model should have provided concrete answers:

- How was the decades-long employment problem supposed to be treated?
- Which therapy was supposed to change the extreme dependence on *Eigenzeit*?
- How was the attachment to the body of work supposed to be classified?
- Which intervention was supposed to reduce problems with transitions and interruptions?
- How was renewed exhaustion through social demands to be prevented?
- What support followed from the diagnosed dysthymia or personality accentuation?

If a model assigns several diagnoses but produces no plausible strategy for changing the central functional problems, its practical explanatory power is limited.

A diagnosis can be formally fitting and therapeutically empty.

In the present case, the autism diagnosis was not merely an identity question for the author. It could have provided a framework for adaptations, accommodations, rights under social law recognition and a changed interpretation of his living conditions.

The alternative diagnoses did not visibly replace this framework. They explained the person differently. But they did not open up an equivalent practical response to the documented problems of life.

Fragmentation Individualises Structural Harm

The distribution across several psychological categories can additionally push institutional and social causes out of view.

Chronic poverty becomes depressive burden. Repeated institutional non-recognition becomes sensitivity to injury. Overload caused by unsuitable working conditions becomes lack of resilience. Communication conflicts become personality problems. Socially produced harms are thereby translated into individual pathologies.

This does not mean that the psychological consequences are unreal.

On the contrary: institutional violence can produce real depression, anxiety and exhaustion.

The question is whether the diagnosis preserves or erases this history of emergence.

If it removes the context, the person appears as the bearer of several disorders while the conditions under which these disorders emerged become invisible.

The fragmentation of the need for explanation is therefore simultaneously a fragmentation of responsibility.

The Counter-Model Would Have to Do More

An alternative diagnostic model would have been convincing if it had shown:

- why the autism screenings were systematically elevated;
- how ADHD and other burdens concretely generated these scores;
- why the partner perceived autistic characteristics to such a strong degree;
- how the decades-long attachment to the body of work could be explained without a special interest;
- why situational social competence was more representative than long-term functional history;
- how dysthymia and personality traits developed over time;
- and which common structure connected the different diagnoses.

Such a model could genuinely have surpassed the autism hypothesis. The mere observation that elevated autism-related scores can also occur in other psychological disorders is insufficient. It demonstrates a possibility of misattribution. It does not demonstrate that this misattribution occurred in the concrete case.

The excuse that a clinic could not accomplish this because of resource limitations does not justify the fact that the clinic, partly directly and predominantly indirectly, publicly conveys the impression that it can do exactly this.

Politics allocates funds to the clinic for particular tasks. If it cannot perform these tasks but nevertheless receives the funds designated for them, a legal and ethical conflict arises.

If it says autism assessment on the label, autism assessment should be inside.

We are not speaking here about errors of judgement, about incorrect professional decisions of the kind that happen everywhere repeatedly, but about objectively demonstrated deficiencies in the methodology and format of the assessment. We are speaking about deficiencies that virtually provoke misdiagnosis.

Diagnostic Parsimony and Diagnostic Truth

In scientific explanations, the principle often applies that no more mutually independent assumptions should be introduced than necessary.

This principle cannot be applied mechanically in psychiatry. People can genuinely have several conditions simultaneously.

Nevertheless, a legitimate question arises:

> *Is a model consisting of ADHD, dysthymia, social anxiety, institutional burden and narcissistic personality traits more explanatory than a model in which autism, ADHD and secondary consequences of burden are considered together?*

The answer cannot follow from the number of diagnoses alone.

What matters is which model:

- integrates more data;
- produces fewer contradictions;
- reconstructs temporal development more plausibly;
- explains differences between contexts;
- and permits better practical consequences.

Precisely this model comparison remained insufficiently visible in the procedure examined.

From Excluded Autism to the Pathologised Remainder

After autism had been excluded, a diagnostic remainder remained.

This remainder consisted of all those characteristics that did not disappear but now had to be explained differently.

The person remained unusually focused. They remained socially exhausted. They remained institutionally conflict-laden. They remained convinced of the significance of their own body of work. They remained convinced that the negative finding failed to capture their reality. Precisely these remaining characteristics could now enter into a personality model.

A dangerous movement thereby emerged:

> *What had previously been submitted as possible evidence for autism became, after autism was excluded, evidence for other disorders.*

The data retained their diagnostic usability.

Only their sign changed.

The Self-Confirmation of the Alternative Model

A fragmented model can easily confirm itself.

High screening scores are interpreted as a consequence of psychological burden. Objection to this interpretation is read as lack of insight or narcissistic injury. Insistence on the attachment to the body of work is understood as self-aggrandisement.

Anger about non-recognition confirms emotional instability or narcissistic sensitivity.

The institutional conflict becomes evidence of a conflict-laden personality style. In this way, every reaction of the person can enter into the alternative model.

The autism hypothesis does not merely lose the diagnostic comparison. The reaction to its exclusion itself becomes material for its further delegitimisation. At this point, fragmentation passes into moral recoding.

An Ethical Difference Between the Models

The choice between diagnostic models also possesses a moral dimension.

An autism model can understand behaviour as an expression of a neurodevelopmental difference, a particular order of relevance and limited capacity for adaptation.

A narcissistic or personality-related model can read the same behaviour more strongly as an expression of self-reference, entitlement, sensitivity to injury or lack of empathy.

Both models influence how the person is treated.

In the first case, they may appear overloaded and mismatched with their environment. In the second, as a difficult, lacking-insight or grandiose personality.

The transition to a personality model must therefore not be made with less care than the examination of autism.

The more morally burdening an alternative category is, the greater the required depth of justification.

The Central Thesis of the Chapter

Humboldt's diagnostic alternative cannot be regarded as superior merely because it named several familiar categories.

What would have mattered was whether it explained the entire life course better than the autism hypothesis.

This was not shown in a traceable way.

The phenomena were divided up. Their connection remained unresolved. The autism hypothesis lost its institutional status. The need for explanation it had captured nevertheless remained.

This process is described here as **fragmentation of the need for explanation**:

> *A possibly coherent functional profile is broken down into several clinically available partial categories without demonstrating that their combination explains the overall biographical structure better.*

Fragmentation is not necessarily wrong. Several diagnoses can correspond to reality.

It becomes problematic when their mere availability is confused with explanation and when the complexity thereby produced no longer appears as a burden of justification for the alternative model.

The decisive question remains:

> *Was a false autism hypothesis replaced by a better model — or was a difficult-to-integrate connection divided up until it fitted the available categories?*

15. The Self-Sealing Interpretation: When Objection Becomes a Symptom

With the moral recoding of individual characteristics, another problem emerged. The personality-related interpretation no longer explained only particular statements and behaviours of the author. It could also absorb his reaction to the diagnostic decision.

Objection to the finding was then no longer exclusively a substantive objection.

It could itself become diagnostic material.

If the author demanded a traceable justification, this could be read as entitlement. If he reacted with hurt or anger, this could be interpreted as sensitivity to injury. If he referred to his own research, publications and professional competence, this could seemingly confirm the assumption of grandiosity.

A **self-sealing interpretation** thereby threatened to emerge:

> *Precisely the attempt to refute the diagnosis could be read as evidence for the diagnosis.*

One is inevitably reminded here of the Rosenhan experiment from 1973. Rosenhan showed how strongly psychiatric interpretive frameworks can determine the perception of a person: once the diagnostic label had been established, even ordinary behaviours were pathologically interpreted within that framework. The present case is not, however, a repetition of this experiment. The author did not feign symptoms, but sought the most accurate possible diagnostic classification with extensive biographical, psychometric and documentary evidence. Nor is this a case of an erroneous psychiatric diagnosis being given to a healthy person, but rather of the possible refusal of a diagnosis despite substantial positive evidence. The structural proximity nevertheless lies in the power of an interpretive framework once it has been established: after the author's behaviour had been read as an expression of ADHD, dysthymia or narcissistic accentuation, directness, objection, systematic documentation and even criticism of the assessment could be interpreted against him within this framework. Rosenhan's study is itself controversial today because of substantial doubts about its documentary reliability; the question it raised nevertheless remains: To what extent does psychiatric diagnosis recognise a person — and to what extent does its interpretive framework first produce the picture that it subsequently believes itself to be confirming?

An Asymmetrical System of Interpretation

In an open diagnostic procedure, an objection would fundamentally have to possess two possible meanings.

It can be an expression of lack of insight, strong emotional involvement or a fixed desire for a particular diagnosis.

But it can also indicate that the diagnostic interpretation is erroneous, incomplete or misleading.

Both possibilities would have to be examined.

A self-sealing system of interpretation loses this openness. It already possesses an explanation for why the person concerned objects. The objection then no longer reaches the content of the diagnosis. It is explained within the diagnosis.

This creates a substantial asymmetry of power.

The institution can interpret the patient.

The patient can criticise the institution.

But his criticism is once again interpreted by the very institution against whose judgement it is directed.

We see this in highly problematic form in many reports from clinics complaining that patients insist on an autism diagnosis. In studies, this is often cited as inappropriate behaviour and as evidence that clinics are ensuring that overdiagnosis does not occur and are fulfilling their responsibility.

But what becomes visible here is that, like Humboldt, many of these diagnostic centres offer no objective external review body that could provide a third perspective, or even objectively hear the objections at all.

This is incomprehensible in the case of a diagnosis as consequential for life and as difficult to obtain as autism. It can certainly be compared with a court judgement. But courts have higher instances that review decisions with serious consequences. Clinics have only the reference to a second opinion, which in reality is often inaccessible to those affected.

If clinics collectively agree that complaining and demanding “pseudo-autistic people” are an impertinence, the threshold for careless condemnation falls again. This leads to those affected being stigmatised directly or indirectly, knowingly or unknowingly, by diagnostic centres.

Added to this is the fact that what autism is is far from as clear as clinics make it appear. The definition of its boundaries is subject to an ongoing process of scientific discourse.

Even if taking this into account would push clinics towards the edge of dysfunctionality, that does not excuse completely excluding the problem.

The Problem of Unfalsifiability

A scientific hypothesis must, in principle, remain correctable through contradictory evidence. This also applies to clinical assessments.

If, however, agreement and objection are equally compatible with the same personality assumption, that assumption loses testability.

If the person accepts the judgement, this can count as insight. If they do not accept it, this can count as sensitivity to injury or lack of insight.

If they calmly explain why the diagnosis does not fit, this can be read as intellectualised defence. If they react emotionally, this can confirm the assumed personality problem.

A model thereby emerges that can absorb almost any possible reaction.

Such flexibility is not automatically a sign of high explanatory power. It can indicate that the interpretation has been shielded against refutation.

In a heated debate about access to assessment and its consequences, precisely this can make the position of clinics appear politically motivated. And that would not be fundamentally wrong. Humboldt's format is not based solely on scientific-clinical necessity.

The Disappeared Substantive Conflict

In the present case, the author's objection concerned concrete points:

- the absence of recognisable examination of the extensive long-term evidence;
- the assessment of the special interest;
- the weighting of high screening and informant-assessment scores;
- the limitations of ADOS;
- the short duration of the assessment;
- the unclear difference between private and clinical assessment;
- the derivation of the narcissistic personality accentuation;
- the use of ICD-10 instead of ICD-11.

These objections could be right or wrong. But they were substantively testable.

As soon as they were read predominantly as an expression of the author's personality, the conflict shifted. The diagnostic justification was no longer at the centre. What now required explanation was why the author did not accept the justification. The substantive conflict could thereby be transformed into a conflict over insight.

It is also to be feared that Humboldt may defend itself against this study in a similar way. That it is, as it were, a consequence of the author's narcissistic injury. Except that this study had already been announced before he received the diagnostic result.

The Double Bind

For the author, this created a situation in which hardly any reaction was safe. If he remained silent, the finding remained in place. If he objected, the objection could be used against him. If he explained in greater detail, he risked appearing controlling, self-referential or grandiose. If he withdrew, his evidence remained unexamined.

Such a structure resembles a double bind:

> *The person is supposed to participate in the diagnostic process and contribute relevant information. But if their participation becomes too persistent or calls clinical authority into question, precisely this participation can be pathologised.*

The right to correction thereby remains formally intact but is practically devalued.

Against this background, the dark history of psychiatry concerning the **pathologisation of dissent** cannot be overlooked.

Institutional Self-Protection

A self-sealing interpretation protects not only the diagnosis. It can also protect the institution.

If the objection must be examined substantively, the finding reopens. Notes, weightings, possible misunderstandings and procedural limitations would have to be reviewed.

If, by contrast, the objection is understood as an expression of personality, the judgement remains closed.

The cause of the conflict then lies not in the quality of the assessment but in the assessed person's inability to accept it.

This shift can occur unconsciously. There does not have to be a conscious intention to repel criticism. Nevertheless, the structure possesses an institutional function: it shifts the need for explanation from the decision to the person who disputes it.

In the documented case, this danger is particularly relevant because the clinic and its leadership had already been the subject of the author's criticism, lawsuit and published research before the assessment began. Clinical judgement and institutional defence could therefore hardly be separated completely from one another.

The Necessary Separation of Objection and Symptom

A scientifically and ethically responsible diagnostic procedure would therefore have to distinguish methodologically between two levels:

> *What does the patient say about the diagnosis?*

and:

What might the manner of their objection reveal about their psychological structure?

The second question may only be asked after the first has been seriously examined.

Otherwise, a possible diagnostic error is stabilised through the reaction to that error.

Particularly in personality assessment, it should be documented:

- which concrete objection was substantively examined;
- how it was answered;
- which corrections were made;
- and why the remaining reaction was nevertheless interpreted as personality-related.

Without this separation, there is a danger of a closed circle.

The Central Boundary

The author had no right to the diagnosis he expected.

He did, however, have a right not to have his objection devalued merely because he objected.

A diagnosis must not become true because the person concerned defends themselves against it.

The decisive test is therefore:

Could the institution, in principle, arrive at a different result on the basis of the objections raised?

If this is genuinely possible, the diagnostic process remains open. This is clear legally as well as scientifically.

16. Bias, Institutional Self-Protection and Epistemic Competition

The case examined did not begin within a neutral clinical relationship.

The author had previously sued the university outpatient clinic, publicly criticised its allocation practice, published an extensive study on the diagnostic emergency, and written directly to the clinic leadership and university leadership. There was even the possibility of an investigation by the public prosecutor's office. The institution also knew that its subsequent conduct was to be scientifically documented. Nevertheless, the assessment was conducted within precisely the clinic that was simultaneously the object of the criticism.

This also surprised the author at the outset. It was clear that the clinic was exposing itself to a massive risk. The author simply had no choice but to accept the offer.

This constellation proves neither a consciously incorrect diagnosis nor deliberate retaliation. It did, however, create an obvious conflict between the clinical task and institutional self-interest.

On the one hand, the clinic was supposed to examine openly whether the author's autism hypothesis was correct.

On the other hand, it had to relate to a claimant and public critic who accused it of structural failure, possible health harms and political responsibility.

Patient and institution therefore did not encounter one another as unburdened participants.

Bias as a Procedural Risk

Bias does not begin only where conscious manipulation can be proven against a person.

For scientific evaluation, the decisive question is initially whether circumstances existed that could endanger impartial assessment or create doubts about its independence in the mind of a reasonable external observer.

Such circumstances existed here:

- The clinic had been directly criticised and sued.
- The leadership knew the author and his preceding study.
- At least one diagnostician was informed about the lawsuit before the first conversation.
- It remained unclear what further information had been passed on internally.
- The leadership of the criticised clinic was a co-signatory of the later diagnostic report. She presumably also sat in the team meeting in which the decision was made.
- The diagnostic result could simultaneously have significance for the credibility of the preceding criticism.

A positive autism finding would not automatically have confirmed the author's study and criticism. It would, however, have strengthened the possibility that an actually autistic person had been excluded and harmed over years by the healthcare system he had criticised.

A negative finding, by contrast, could indirectly relieve the institutional position. The clinic's sharpest critic would then, from its perspective, not be the autistic person he claimed to be, but a person with other psychological and personality-related problems.

Precisely for this reason, the independence of the procedure should have been protected with particular care. For what now occurred was a disaster for Humboldt. It had devalued a critic through the means of psychiatric diagnosis, something that could not remain without consequences for the content of his criticism.

According to the documented structure, Humboldt did not refer people exclusively to its own clinic but also coordinated access to other diagnostic centres. It could therefore at least have been examined whether, in order to avoid a conflict of interest, the author should have been referred to another institution.

Whether such an examination took place is unknown.

Silence did not create neutrality. Rather, it deprived the author of the possibility of realistically assessing the conditions of his examination.

Nor could he intervene in the methodology, meaning raise an objection to ADOS, because he effectively had to be grateful to be assessed at all. This is a massive problem.

The Institutional Observer Effect

In the present case, the situation was shaped by a substantial power imbalance. The clinic controlled the almost unattainable assessment place, possessed clinical authority and had the capacity to produce a finding with legal effect. The author depended on this decision even though he had previously attacked the same institution publicly.

His tension was therefore not independent of the institutional history. Showing anxiety here would have been an entirely normal reaction.

The assessment should have asked:

> *Which observed reactions belong to the long-term personality or functional structure, and which were produced by the concrete space of conflict?*

This distinction was not visibly made in the report.

This created the risk of individualising institutionally produced reactions.

The institution produced uncertainty. The patient appeared mistrustful. The institution left its state of knowledge unclear. The patient attempted to control the situation. The institution barely responded to his objections. The patient explained more extensively and insistently. Each side therefore influenced the other. Yet diagnostically, mainly one side was evaluated.

Clinical Relationship or Institutional Opposing Position?

The relationship changed at the latest during the feedback meeting.

The author was no longer merely a patient receiving a distressing result. He simultaneously reappeared as a critic of the methodology and the institution. The diagnosticians had not only to explain a judgement, but in practice also to defend the clinic and its procedure. A shift of roles thereby occurred.

The clinical task would have consisted of:

- explaining the result in a traceable manner;
- containing the emotional reaction;
- disclosing uncertainties;
- examining misunderstandings;
- and clarifying further steps of care.

The institutional task, by contrast, consisted of:

- defending the validity of the procedure;
- stabilising the decision already made;
- and responding to the author's criticism.

The two tasks could collide.

According to the documentation, the author increasingly no longer experienced the diagnosticians as treating professionals, but as representatives of an institution against which he had to defend himself. The remark that he could always complain reinforced this impression. It formally referred him to a legal remedy without addressing the substantive conflict within the conversation.

The patient thereby effectively became the opposing party of the institution.

Precisely at the moment when he was particularly vulnerable because of the negative finding, the clinical relationship completely lost its protective function. The author was allowed to leave the room in a state of rage, into which he had been pushed because the appointment was time-limited and not a single word of his criticism was substantively addressed.

Institutional Self-Protection

Institutions have a legitimate interest in protecting their staff, procedures and professional decisions against unfounded attacks. Institutional self-protection is therefore not fundamentally illegitimate.

It becomes problematic when it enters unnoticed into a clinical judgement or prevents that judgement from being reopened afterwards.

In the present case, the clinic had to deal with unusually severe criticism. The author had accused it not merely of organisational errors, but of severe health harms, political concealment and possible co-responsibility for deaths.

Such criticism almost inevitably produces defensiveness.

People and institutions defend their self-image, their professional integrity and their public legitimacy. The older diagnostician behaved in exactly this way during the conversation.

The scientific question is therefore not whether some form of defensiveness was probable. It is:

> *Which safeguards prevented this defensiveness from influencing diagnostic perception?*

Precisely here, no recognisable safeguards can be found in the documented procedure. If they existed, they obviously did not work. The author left the clinic traumatised.

Epistemic Competition

The conflict was not merely personal and institutional. It also had a scientific level.

In his work, the author represented an autism model (Critical Autism Studies) more strongly oriented towards:

- subjective experience;
- masking;
- monotropism;
- different orders of relevance;

- long-term forms of attachment;
- institutionally produced disability;
- and the epistemic competence of autistic people.

The clinical diagnostic process, by contrast, appeared more strongly oriented towards classical core domains, observable social interaction, standardised procedures and established differential-diagnostic categories.

Thus, not merely two assessments of an individual case stood against one another. Two forms of knowledge production encountered each other.

One proceeded primarily from clinical observation and institutionally established classification. The other proceeded from life history, internal perspective and the long-term morphology of the case.

This epistemic competition increased the risk that the author would not be perceived as a possible professional interlocutor, but as a patient with an overvalued personal theory.

His expertise could be devalued precisely because it called the foundations of the clinical model into question. The respective forms of expertise came from different disciplines: the clinical model and Critical Autism Studies.

The Conflict Between Roles

The author's roles were difficult to reconcile. As a patient, he was supposed to be open, vulnerable and cooperative. As a claimant, he had to watch for possible procedural errors. As a researcher, he observed institutional behaviour. As an activist, he wanted to make structural harms visible. As an author, he defended the scientific relevance of his body of work.

Each of these roles was understandable within the concrete context. In combination, however, they produced behaviour that had to appear unusual in an ordinary clinical situation.

The clinic likewise possessed several roles:

- diagnostic institution;
- scientific institution;
- criticised organisation;
- political actor within the healthcare system;
- possible opposing party in litigation;
- and producer of a later legally relevant finding.

The case was therefore structurally overloaded. A careful institutional response would have separated these roles. Instead, they were combined within a single procedure.

The Diagnosis as a Possible Act of Institutional Relief

It cannot be proven that the negative result was intended to relieve the institution. It can, however, be analysed what relieving effect it had.

If the author had been recognised as autistic, this would have supported his preceding account that, as an autistic person, he had been harmed by the diagnostic emergency and by other institutions.

With the exclusion of autism, the interpretive framework shifted.

The conflict could now appear more strongly as the conflict of a non-autistic, possibly narcissistically accentuated patient with a professionally acting institution.

The institution did not necessarily have to reassess its own role.

The disorder once again lay more strongly with the person.

This effect proves no intention.

It does, however, show why an independent procedure would have been necessary.

Where the diagnostic result simultaneously relieves the institution that produces it, the possibility of structural self-benefit must be taken particularly seriously.

Prof. Dziobek and the Humboldt leadership apparently failed completely here and showed what appears to be a negligent handling of the entire procedure. They put at risk not only the reputation of the university, but also the author's health.

Trust as a Methodological Requirement

Diagnosis depends on trust. The person being assessed must disclose intimate experiences, reveal contradictions and also provide information that may speak against their own hypothesis.

This trust presupposes that they experience the diagnosticians as sufficiently independent. In the present case, this condition was weakened from the outset.

The author did not know who knew what about him. He did not know how his lawsuit had been represented internally. He did not know what role the clinic leadership played in the case discussion. He did not know whether his criticism was being read as a professional objection or as an indication of his personality.

The institution could have reduced this uncertainty through transparency. Because it did not do so, mistrust became a rational component of the situation. It would therefore be methodologically reductive to attribute the lack of trust solely to the patient.

Bias Does Not Have to Be Proven to Be Relevant

For the argument of this study, it is not necessary to establish actual conscious bias.

The stronger and better-supported statement is:

> *The procedure exhibited a substantial and foreseeable risk of bias without transparent safeguards against that risk being recognisable.*

This is sufficient to critically examine the validity of the result.

Scientific reliability does not rest solely on the personal integrity of those involved. It also rests on procedural structures that limit possible distortions.

An institution cannot expect those affected simply to trust that nobody allowed themselves to be influenced. It must show how independence was established.

Humboldt did not do this.

The Central Ethical Omission

The central omission therefore did not necessarily lie in demonstrable manipulation of the finding.

It already lay before that:

- The conflict was not disclosed.
- The internal state of knowledge remained opaque.
- Independent referral was not recognisably considered.
- The roles of the clinic leadership were not clarified.
- The institutional context was not visibly taken into account when evaluating behaviour.
- And there was no immediately accessible route for independent review of the result.

A procedure was thereby conducted whose result, irrespective of its substantive correctness, predictably had to remain under suspicion of institutional defensiveness.

This harmed not only the author.

It also harmed the credibility of the diagnostic process. And the reputation of the Humboldt clinic, possibly Humboldt University itself.

The actions of the leadership are all the more surprising because the author had already announced a second study in advance in order to measure the reactions to the first study.

To exaggerate the image, they knew that the Michelin inspector (narcissism) was coming to the restaurant, but treated him like an impertinent guest and, out of indifference, served him the same cold noodles as everyone else.

This also indicates that they did not take the author's work seriously. They did not take him seriously as a researcher. Why, then, would they have read his materials in relation to the assessment?

Neither Prof. Dziobek nor President von Blumenthal replied to the author's emails, even though these explained massive ethical problems concerning the clinic and the lottery procedure that may, under certain circumstances, have contributed to deaths.

Why did neither the university leadership nor the clinic leadership respond to the allegations, but then instead invite the author to assessment?

The Core of the Problem

The case does not permit a confident claim that the clinic produced a negative diagnosis out of revenge, defensiveness or institutional self-protection.

It does, however, permit a clearer finding:

> *An institution diagnosed its own public critic without making the existing conflict transparent and without visibly separating the diagnostic decision from its own institutional interests.*

This created an avoidable credibility problem.

The clinic claimed to assess the author clinically. At the same time, it remained unresolved to what extent it already perceived him as an opponent, claimant and threat to its public legitimacy.

Precisely for this reason, the diagnostic result cannot meaningfully be examined without taking the institutional history into account.

The following chapter turns to the consequences of this relationship within the feedback meeting. There, clinical decision, institutional defensiveness and communicative power condensed into a situation that the author experienced as gaslighting and as a profound destabilisation of his own perception. This had high traumatising potential because it was not the first time this had happened to him.

17. Gaslighting and Epistemic Destabilisation in the Feedback Meeting

In the feedback meeting, several problems that had already existed previously became concentrated: the institutional history, the opaque state of knowledge, the lack of traceability of the overall assessment, the diagnostician's suggested private divergence, and the personality-related interpretation of objection.

The author experienced this communicative situation as gaslighting.

This does not prematurely assert that the diagnosticians consciously and systematically attempted to make him doubt his own mind. The term initially refers here to the concrete effect of communication in which a person's perception is repeatedly destabilised without the contradictions thereby produced being transparently resolved.

For the author, the destabilisation consisted particularly in several messages becoming effective at the same time:

- The assessment was supposedly neutral, even though the institution knew about the lawsuit and the preceding criticism. This was certainly threatening for Humboldt.
- All information had supposedly been taken into account in an overall assessment, even though it remained unclear which materials had actually been read and integrated.
- The diagnostician suggested a private divergence, but did not state it clearly.
- The scientific limitations of the procedure were acknowledged without the result being restricted accordingly.

- The author was permitted to object, but received no traceable substantive answer to central objections.
- At the same time, his objection could enter into a personality-related interpretive model.

What emerged was therefore not an ordinary professional disagreement. A communicative space emerged in which the author could no longer confidently identify which level of statements was supposed to apply.

"Privately, I See It Differently"

According to his recollection, particularly destabilising was the older diagnostician's repeated suggestion that she privately assessed certain questions differently, but was clinically bound by the requirements.

Such a statement can initially have a relieving effect. It may signal understanding and make visible that professionals too recognise the limitations of diagnostic systems.

In the concrete case, however, it produced additional uncertainty.

If the diagnostician privately thought differently, the immediate questions were:

- What did this divergence refer to?
- Did she consider autism possible despite the finding?
- Was she criticising only individual criteria?
- Did she not fully agree with the outcome of the case conference?
- Or did she merely want to show empathy without questioning the decision?

Because the private position was not stated, it could neither be understood nor examined. It remained in the room as an implication and thereby intensified precisely the contradiction between professional uncertainty and institutional certainty.

The author received the message that he might be perceiving correctly that something was wrong with the result. At the same time, he was deprived of every possibility of objectifying this perception.

Non-Response as a Communicative Act

Gaslighting-like effects do not arise only through explicitly false statements. Systematic non-response can also destabilise a person's perception.

The author raised concrete objections during the feedback meeting:

- the almost thirty-year attachment to the body of work;
- the high screening scores;
- the limitations of ADOS;
- masking and compensation;
- the short duration of the procedure;
- the absence of recognisable examination of his materials;

- and the questionable derivation of the narcissistic personality accentuation, which was then also presented in the finding in an irritating way that resembled a full narcissistic personality disorder.

According to his documentation, the diagnosticians responded to these objections predominantly not with a traceable comparison of models. Instead, reference was made to the overall assessment, the applicable criteria and the possibility of making a complaint.

For the professionals, this could mean that the decision had already been concluded and that the feedback meeting was not intended to serve as a renewed assessment.

For the author, however, it meant that his objections were neither explicitly refuted nor acknowledged as justified.

He spoke.

The institution did not respond on the same level.

A communicative void thereby emerged. The author did not know whether his arguments had not been understood, not believed, not read, or simply not institutionally permitted.

One can imagine what something like this does when one has waited years for an assessment appointment and the clinic then slams the door in one's face and refuses to correct objectively established deficiencies.

This is a form of institutional violence that renders one speechless.

"Then Go Ahead and Complain"

Particular significance attached to the approximately equivalent or, according to the author's recollection, literal statement made several times in roughly the following form:

> *"Well then, go ahead and complain. You are welcome to do that."*

Formally, such a statement refers to a legitimate right. Patients are permitted to complain about an assessment. Within the concrete power relationship, however, the remark could have a different effect.

The diagnostician knew that the author had already undertaken extensive complaints, lawsuits and political steps. She knew or could have known that these procedures had over long periods produced hardly any substantive clarification. She spoke from the position of a university specialist clinic, while the author was in a state of considerable exhaustion and existential dependence.

The statement therefore referred to a formal possibility whose practical limitations were part of the preceding conflict.

For the author, it could be experienced as mockery, in the sense of:

> *You can complain, but we both know who holds the power in this structure.*

Whether this effect was intended cannot be established. For ethical evaluation, however, foreseeable effect is also relevant.

The Destabilisation of One's Own Perception

As a consequence of the communication, the author began to doubt his own perception and his own mind.

This reaction is understandable in the context of the four realities.

His life history continued, from his perspective, to speak clearly for autism.

Scientific research left open the possibility of a false-negative result.

The diagnostician suggested that privately she did not fully agree with the clinical level.

The official report nevertheless stated unequivocally that autism was not present.

At the same time, the author's scientific competence was not visibly recognised, and his insistence could be read as an expression of a personality problem.

He therefore had to decide not only which diagnosis was correct.

He had to decide whether his entire capacity for self-observation, scientific examination and interpretation of his own life had become unreliable.

Precisely therein lay the epistemic destabilisation with which he was left alone.

Patient, Critic or Opponent?

The feedback meeting should have been a clinical protective space in which a potentially highly distressing result was explained and contained.

In reality, at least three roles became mixed:

- The author was a patient.
- He was a critic of the diagnostic result.
- He was a public opponent of the institution.

The diagnosticians likewise moved between roles:

- They communicated a clinical finding.
- They defended the methodology.
- They represented an institution that had previously been criticised.

The more strongly the author attacked the result, the more institutional defence moved into the foreground.

His role as patient thereby threatened to disappear. As did the clinic's duty of care.

He was no longer treated only as a vulnerable person who had been denied an existentially significant diagnosis. He increasingly appeared as someone calling the authority of the clinic into question and whose attacks had to be repelled.

The institution saw the opponent.

The patient was left with the injury.

Injury at a Highly Vulnerable Moment

A negative autism diagnosis can be extraordinarily distressing for those affected, particularly when it follows prolonged self-examination, years of searching for access and substantial health pressure.

This does not mean that clinics must assign a diagnosis in order to avoid crises. It does mean, however, that they must take the foreseeable consequences of their communication seriously.

In the present case, several vulnerability factors were known:

- severe exhaustion;
- long-standing social and material crisis;
- high existential significance of the diagnosis;
- ongoing legal proceedings;
- extreme scarcity of further diagnostic options;
- and an already escalated institutional conflict.

Precisely under these conditions, the feedback meeting should have required particular care:

- sufficient time;
- a clear distinction between established result and remaining uncertainty;
- concrete answers to central objections;
- a robust recommendation for further steps;
- and a support structure for possible crises.

According to the author's documented experience, this did not occur to a sufficient extent. Beyond this, after that experience it seemed inconceivable to ask the clinic for help. If only the perpetrator remains as the source of assistance, and that perpetrator is the state, meaning a state institution, then this destabilises one's relationship to the world and one's trust in it.

The Failure to Contain the Aftermath

The clinic produced a finding with far-reaching consequences without providing an equivalent structure for dealing with those consequences. Calling after the author, once he had stormed out of the clinic in anger, *"If you have questions, call us"* appeared hardly credible in this situation, since they did not intend to change anything anyway. It would only have injured the author again.

Access to help had therefore been blocked by the clinic itself.

According to the author's account, there was:

- no immediately accessible independent second review;
- no recognisable crisis follow-up;
- no robust alternative explanation of his entire life structure;
- no concrete answer to the continuing functional problems;

- and no recognisable assumption of responsibility for the destabilisation during the conversation.

The author was discharged with a new institutional description:

not autistic, dysthymic and narcissistically accentuated.

His experience nevertheless remained. The overload remained. The attachment to the body of work remained.

The social and occupational problems remained.

The diagnostic explanation that had connected these phenomena for him had been institutionally devalued without being replaced by an equivalent model.

Gaslighting as Effect, Not as Imputed Intention

A clear conceptual boundary is necessary for scientific presentation.

Not every incorrect diagnosis is gaslighting. Not every evasive answer is conscious manipulation. Not every form of institutional defensiveness aims to psychologically destabilise a person.

The term is nevertheless justified here if it is used as an **experienced and structurally comprehensible effect**.

The communication was gaslighting-like because it:

- initially rendered institutional prior knowledge invisible;
- did not disclose its own clinical subjectivity;
- produced contradictory messages;
- suggested doubts without making them speakable;
- neither confirmed nor traceably refuted central perceptions of the author;
- and potentially pathologised his reaction to this uncertainty again.

The effect consisted in destabilising the author's trust in his own perception.

It also left him without any possible solution in a massive conflict.

Methodologically Produced Disorientation

The case suggests that this effect did not arise only from the behaviour of individual diagnosticians. It could also result from the methodology of the system.

The diagnostic process demanded openness while keeping its own production of knowledge closed.

It collected subjective data while rendering clinical interpretation invisible. It named methodological limitations while communicating an unequivocal result. It permitted objection without providing a visible correction procedure. It treated the person as a patient until he attacked the institutional decision, and thereafter increasingly as a party to a conflict.

This structure can also occur in other clinics without individual professionals consciously acting manipulatively.

The gaslighting-like quality would then not merely be an individual communication disorder. It would be a possible **system effect of opaque and non-participatory diagnosis**.

This could arise wherever autism assessment fails structurally while unequivocal results are asserted with great confidence.

The Ethical Boundary

A diagnostic institution is permitted to disagree with a person. It is permitted to reject their self-diagnosis. It is also permitted to reach a conclusion that deeply disappoints them.

It must not, however, make its own methodological and institutional limitations so invisible that the person is ultimately left with only two possibilities:

> *Either the institution is wrong, despite possessing all the power and authority.*

or:

> *The entirety of one's own perception, research and interpretation of one's life is the expression of a psychological misstructure.*

Between these poles, the diagnostic process should have kept open a space of scientific uncertainty.

Precisely this space was absent.

This is not only a problem of the Humboldt clinic, but concerns very many diagnostic centres.

The Core of the Ethical Failure

The ethical problem therefore did not lie solely in the negative finding.

It lay in the combination of:

- an opaque institutional history;
- non-traceable weighting of evidence;
- suggested private divergence;
- a morally burdened alternative interpretation;
- lack of substantive response to objections;
- a considerable power imbalance;
- and inadequate follow-up care.

This combination transformed the feedback meeting from a clinical situation of explanation into an epistemic and institutional confrontation.

At a highly vulnerable moment, the author was not reliably contained as a patient.

He was confronted with a judgement whose path of reasoning he could not understand despite, or precisely because of, his knowledge of autism, and at the same time referred to a complaints system whose practical ineffectiveness had already formed part of his preceding research.

The following chapter extends this analysis beyond the individual case. It examines whether negative autism assessment under conditions of resource scarcity systematically claims more than its methodology can deliver — and whether a limited procedure of recognition is transformed into an institutional statement about the non-existence of autism.

18. When Resource Scarcity Becomes an Ontological Statement

The analysis so far has concerned the concrete production of a negative finding. The question must now be asked whether this reveals a more general problem in adult autism assessment.

Specialist clinics operate under considerable resource scarcity. The number of requests far exceeds the available places. Diagnostic procedures must therefore be limited in time, standardised and organisationally manageable. Not every biography can be reconstructed in its full depth, not every material can be read completely, and not every uncertainty can be resolved through further appointments.

This limitation is initially a fact of the healthcare system.

The ethical problem begins where a limitation of the procedure is turned into a statement about the reality of the person.

Under its concrete conditions, a clinic can establish:

> *The criteria for an autism diagnosis could not be confirmed with sufficient certainty within the present procedure.*

This statement describes the reach of the investigation.

Something different is the statement:

> *The person is not autistic.*

This sentence no longer describes the procedure. It describes the being of the person examined. Between these two statements lies a methodologically and ethically substantial step.

Recognisability Is Not Existence

Diagnostic procedures do not directly capture autism. They capture particular characteristics under particular conditions and translate these into a diagnostic decision using defined criteria.

The decisive question is therefore not only whether autism is present.

It is also:

> *Is this autism recognisable within the procedure being used?*

These two questions must not be confused with one another.

An autistic profile may be barely visible in a brief, structured one-to-one interaction. Early developmental data may be missing. A person may have learned social skills over decades, compensated for symptoms and organised their life in such a way that problematic situations are avoided. Comorbidities may obscure the picture. The content of a special interest may appear socially ordinary even though its form of attachment is extraordinary.

In such cases, diagnostic recognisability may be reduced without this deciding the existence of the underlying phenomenon.

The sentence:

> *"We did not recognise it sufficiently"*

is not identical with:

> *"It is not present."*

Precisely this distinction threatens to disappear in clinical practice. And this is a massive political and legal problem, which is why the autistic community worldwide is rightly up in arms and asks by what right clinicians, usually neurotypical, presume to judge neurodivergence when they provide neither the necessary resources nor error-free methods to do so.

The Diagnostic Filter

Under resource scarcity, diagnosis inevitably becomes a filter.

But it does not filter only autism.

It also filters:

- obvious versus subtle profiles;
- easily observable versus strongly compensated characteristics;
- well-documented versus incomplete developmental histories;
- standardisable versus biographically complex presentations;
- and institutionally familiar versus unusual forms of autistic life organisation.

The procedure therefore does not select only according to who is autistic.

It selects according to **who appears sufficiently autistic under its conditions**.

This distinction is central to scientific and ethical evaluation.

A diagnostic system can possess high accuracy for those profiles to which its instruments, interviews and clinical expectations are particularly well adapted. At the same time, it can systematically capture other profiles less well.

If this selection effect is not made transparent, the negative result appears as a characteristic of the person instead of as a possible product of the filter.

The Invisible Resource Decision

Scarcity enters into the diagnostic judgement at several points:

- It limits the number and duration of appointments.
- It reduces the possibility of examining extensive long-term evidence.
- It makes follow-up questions and correction loops more difficult.
- It favours standardised, quickly evaluable procedures.
- It limits independent second opinions.
- It increases the pressure to produce an unequivocal decision at the end.
- And it often prevents doubtful cases from being observed over a longer period.

These resource decisions, however, are rarely made visible as part of the finding.

The report does not state:

> *"Because of the available time budget, the submitted books and long-term documents could only be examined to a limited extent."*

It does not state:

> *"Further biographical exploration would have been scientifically useful, but was not possible within the healthcare setting."*

Instead, the result appears as an overall professional statement. Why is that? Presumably because otherwise the clinics would, over the longer term, delegitimise themselves. The health insurer would begin asking questions about what exactly it is paying for here.

Instead, an organisational limitation is translated into epistemic certainty.

The institution can absorb a particular amount of reality. What lies outside this capacity receives hardly any weight in the result.

The reduced representation is subsequently treated as the overall picture of the person.

Scientifically and ethically, this is massively dishonest. It can become a form of conscious deception.

Methodological Insufficiency or Negative Result?

A negative result can have different meanings.

It can mean:

1. The data genuinely speak clearly against autism.
2. Individual autistic characteristics are present, but the required overall pattern is absent.
3. The data are contradictory and do not permit a reliable decision.
4. The procedure could not adequately capture substantial parts of the case.
5. The available resources were insufficient to resolve the uncertainty.

These possibilities must not disappear into a single category of "no autism".

The final two variants in particular do not primarily concern the person. They concern the performance limits of the institution.

It makes no difference whether, internally within clinical language, particular coded formulations indirectly introduce a qualification. Certain clinical codes indirectly acknowledge ambiguity. It must be stated clearly and plainly, recognised by the state and placed prominently in front of everyone, that what is being decided here is not autism as an ontological certainty, but that a particular methodology — the only one that is funded — opens up a space within which some are recognised as autistic and others are not.

Anything else, or allowing such findings to be used by courts as evidence, has nothing or very little to do with reality. The limits of autism assessment must be clearly stated, and precisely that did not happen here.

The Cut-Off as an Administrative Boundary

The problem becomes particularly clear with diagnostic thresholds.

A cut-off separates ranges of scores within an instrument. It serves standardisation and decision support. It does not, however, represent a natural boundary between two clearly separated groups of human beings.

A person just below a threshold is not necessarily fundamentally different in experience and functional profile from a person just above it.

The threshold decides how a result is classified. It does not by itself decide what the person is.

Particularly with heterogeneous and dimensionally distributed characteristics, a small difference in score can produce substantial institutional consequences:

- above the cut-off: further examination or diagnostic recognition;
- below the cut-off: exclusion, lack of support and possibly an alternative pathologisation.

A statistical decision aid thereby becomes a social boundary. And this has a massively discriminatory effect. It violates fundamental legal principles such as equal treatment.

The Ethical Right to Negate

This gives rise to a provocative but necessary research question:

> **Does a diagnostic institution possess the ethical right to describe a person as non-autistic when its methodology cannot reliably exclude autism in that specific profile?**

The question is not directed against negative diagnoses as such.

It must be possible to reject an autism hypothesis. Otherwise, diagnosis would be meaningless.

The rejection must, however, correspond to the degree of available evidence and the certainty of the procedure.

The more strongly the following factors are present,

- clearly elevated screening scores;
- conspicuous informant assessments;
- a plausible history of masking and compensation;
- decades-long functional abnormalities;
- high biographical explanatory density;
- incomplete early developmental data;
- and limited validity of direct observation,

the less legitimate a categorical exclusion becomes without an explicit formulation of uncertainty.

The professionally honest statement might then have to be:

> *The criteria could not be sufficiently confirmed within the present procedure; however, autism cannot be reliably excluded because of the limited and contradictory data.*
>
> *Of course, this would create a political problem if thousands of possible autistic people began knocking on the doors of courts and demanding clarification so that they too could be granted rights to which they are entitled. And this conflict is overdue and desirable.*

The Asymmetrical Consequences of Diagnostic Errors

Every diagnostic procedure must reckon with false-positive and false-negative results.

The debate often concentrates on the danger that people might incorrectly receive an autism diagnosis. This concern is legitimate. An incorrect diagnosis can distort treatment, self-understanding and allocation of resources.

False-negative results, however, likewise have substantial consequences:

- appropriate support remains inaccessible;
- secondary disorders may be treated incorrectly;
- the person loses a coherent explanation of their life history;
- rights under social law claims may fail;
- masking and overload continue;
- and future treating professionals orient themselves towards a negative finding.

In addition, a rejected person often does not return to a neutral state.

They may receive other diagnoses, including morally burdened personality attributions.

The false-negative error then does not merely mean:

> *Autism was overlooked.*

It can mean:

Autism was overlooked, and the reaction to being overlooked was documented as a personality problem.

This consequence of error is particularly severe.

Who Bears the Risk of Uncertainty?

Under scarce resources, it must be decided how uncertainty is distributed.

The current model can lead the institution to reduce its own uncertainty through an unequivocal judgement.

The patient then bears the risk that this judgement was wrong.

The clinic closes the case.

The person affected continues to live with:

- unchanged limitations;
- lack of recognition;
- more difficult access to support;
- and possibly damaged trust in their own perception.

The risk of diagnostic uncertainty is thereby shifted downwards.

An ethically responsible practice would have to ask:

Is it justified to eliminate institutional uncertainty through categorical exclusion when the consequences of a false-negative judgement fall almost entirely on the person affected?

Resource scarcity does not make this question less important.

It makes it more urgent.

Resource Scarcity Does Not Justify Exceeding the Reach of Knowledge

That clinics are overloaded is itself part of the problem. Individual diagnosticians do not bear sole responsibility for a politically produced shortage of healthcare provision.

Scarce resources, however, do not create a right to exceed the reach of one's own knowledge.

An institution may say:

We cannot provide more than this.

It cannot simply infer from that:

There is nothing more to recognise.

That would be the ontologisation of resource scarcity:

What does not become sufficiently visible within the available procedure is treated as absent within the person.

The boundary of the budget becomes the boundary of being.

It would only be healthy if the collapse of the healthcare system actually became visible here and were not concealed through false statements by clinics.

Diagnostic Industry and Selection Logic

The term **diagnostic industry** is not used here to impute motives of economic enrichment to individual professionals. It refers to a system that must process large numbers of highly complex individual cases through limited, standardised and repeatable procedures.

This system requires:

- fixed appointment lengths;
- standardised instruments;
- billable units;
- comparable documentation;
- diagnostic categories;
- and cases that can be closed.

The individual person must be brought into a form that can be processed within this structure.

Complex cases call this mode of production into question. They require more time, more interdisciplinary examination, more feedback and possibly an open-ended result.

Yet precisely they are reduced most strongly by industrial logic.

This creates the danger that it is not the clearest cases that are filtered out, but those whose autism would require too much epistemic work.

Who Falls Through the Filter

The people excluded by the filter do not disappear.

They remain with their experience.

They may continue to experience:

- social alienation;
- sensory or communicative overload;
- extreme attachments and routines;
- limited flexible capacity for employment;
- masking;
- burnout;
- and the necessity of organising life around particular functional limits.

What disappears is the institutional recognition of this connection.

The person may remain autistically organised but be socially treated as non-autistic. This creates a particular form of diagnostic abandonment and discrimination:

> *The connection is rejected without its effects disappearing.*

The institution closes the file. The person remains inside the problem.

Particularly for autistic people recognised late or, as here, not recognised at all, the suffering already endured over decades is simply imposed upon them further.

The Reversal of the Impostor Suspicion

In public and partly also professional discourse, self-identified autistic people are frequently suspected of seeking a fashionable label, uncritically adopting social-media narratives or using a diagnosis to elevate themselves.

This possibility may exist in individual cases.

It becomes problematic as a general interpretive framework.

Because it conceals the opposite possibility:

> *It may not be the person affected who is deceiving others about autism. The healthcare system may be deceiving others about the certainty of its own capacity to exclude it.*

The institution appears as the objective authority. The self-diagnosed person appears as the potential impostor.

But if the procedure can methodologically capture certain profiles only to a limited extent, this distribution of roles is not self-evident.

The Provocative Question of Deception

At this point, the question arises whether such a structure can be described as a form of institutional or epistemic deception.

The legal concept of fraud is not readily applicable here. It requires specific legal elements that are not being asserted in this investigation.

As an ethical research question, however, the concept remains productive:

> *Is the person affected being deceived about the evidential power of the procedure when a resource-limited filter is presented as a comprehensive examination of autism?*

Such a structure of deception could exist where:

- the institution has known methodological limitations;
- certain complex profiles are therefore recognised less reliably;

- the limitations are not communicated in an understandable way;
- and a negative result is nevertheless presented as a far-reaching statement about the person.

The decisive issue would not be the individual intention of the diagnosticians. It would be the structural difference between what the procedure can actually achieve and what the finding claims to achieve in relation to the person.

Humboldt crossed this boundary.

Nevertheless, it can of course continue to recognise some autistic people. (According to Prof. Dziobek, currently only around 30% of those presenting for autism assessment receive a positive diagnosis.) But Humboldt must no longer imply that it conducts an assessment capable of fundamentally resolving the question conclusively.

An ethically responsible diagnostic process would have to develop a language that reflects its own reach. Such language does not weaken clinical authority. It makes it scientifically credible. It does, however, weaken artificially inflated authority looking towards third-party funding.

The Core Research Question

The present case suggests an overarching research question:

> *How many false-negative autism diagnoses are produced in adult healthcare not because autistic characteristics are absent, but because the available procedures, time budgets and clinical models cannot adequately capture their concrete form?*

This question must be pursued together with the debate about possible overdiagnosis.

It is not sufficient to investigate whether too many people receive a diagnosis.

It must likewise be investigated:

- which profiles are regularly rejected;
- how reliable these exclusions actually are;
- which alternative diagnoses are assigned;
- what consequences arise from them;
- and whether a rate of false-negative decisions is institutionally accepted for resource reasons.

The ethical scandal would then lie not only in inadequate access to diagnosis.

It would also lie in the fact that scarce access itself produces a procedure that must reduce complex people and subsequently presents its own reduction as truth about those people.

The limit of diagnosis becomes the limit of identity.

The following chapter examines the consequences of this operation. For a negative diagnosis does not simply leave behind a diagnostically neutral person. It can withdraw institutional recognition of an identity while the underlying experience remains completely intact.

19. Diagnostic Identity Erasure: The Experience Remains

A negative autism diagnosis does not return the person being assessed to a neutral state.

The difficulties for which they sought assessment do not disappear. Social overload, masking, limited flexible capacity for work, attachment to particular routines or interests, exhaustion and recurring crises remain. What changes is the institutional meaning of these experiences.

The connection through which the person may for the first time have been able to understand their life is not recognised.

The diagnosis disappears.

The experience remains.

This process can be described as **diagnostic identity erasure**.

This does not mean that an institution could completely erase a person's inner identity. The person affected may continue to understand themselves as autistic. They may continue to explain their biography through autism and find support in autistic communities.

What is erased, rather, is the institutional validity of this identity.

This is not a trivial matter. On a certain structural level, the constellation recalls the historically painful medical and state treatment of homosexuality and queer life, whose consequences extend into the present. This is not intended as an equation of sexual orientation and neurodivergence, but as a comparable form of institutional authority over identity: an external authority claims the right to decide on the legitimacy of a self-description even though the lived experience of the person affected cannot be fully captured or objectively measured from outside. If a neurologically or sexually grounded identity is prevented by the state, medicine or society from being lived and recognised, long-term psychological, social and biographical harms can result.

Precisely because autism is not an illness in the classical sense, but describes a form of neurological development and relationship to the world, the final word over identity and belonging cannot lie without restriction with diagnosticians. Autism cannot be measured unequivocally like a laboratory value. Assessment works with behavioural observations, biographical information, informant reports, standardised instruments and interpretive models. It can therefore substantiate a clinical assessment, but it cannot fully capture the totality of experience. Similar to sexual orientation, autistic experience cannot be conclusively proven or disproven from outside.

If substantial parts of this experience are in principle only partially accessible diagnostically, the question therefore arises whether clinical diagnosis is even the correct place for a comprehensive ontological determination of the person. It can decide whether it assigns a diagnosis according to its criteria. It does not automatically follow from this that it possesses the authority to determine conclusively the reality, identity and legitimate self-description of a human being.

This question acquires additional significance because neurodivergent people face substantial social barriers and discrimination. The resulting disabilities are not exclusively properties of the individual, but arise substantially in the relationship between person and environment. If society does not

sufficiently reduce these barriers, it cannot simply attribute the resulting burden to the individual while simultaneously subjecting access to support to narrow diagnostic gatekeeping. Otherwise, a circular logic arises: support is granted only when an institutionally recognised disability exists; yet the same institutions determine, under conditions of limited resources, which forms of disability are recognised at all.

A structurally problematic logic follows from this:

> *Autism cannot be measured safely and completely. At the same time, there is a high need for support under limited resources. Under these conditions, an institutional incentive arises to design diagnostic thresholds and procedures so that the number of recognised persons remains compatible with the available resources.*

This would, however, translate a resource decision into a statement about the person. Access to help would no longer be determined solely by the existing functional and support profile, but by the ability to be recognised as sufficiently unequivocally autistic within a limited diagnostic system. The methodological and material limits of the healthcare system would thereby threaten to become the identity and participation limits of those affected.

Identity and Diagnosis Are Not Identical

Autism is not merely a medical label. For many adults recognised late, the concept becomes a model that connects experiences previously separated from one another:

- social alienation;
- sensory or communicative overload;
- unusual forms of interest and attachment;
- the costs of constant adaptation;
- contradictory abilities;
- and decades of failure despite high competence.

The diagnosis does not create these experiences.

It gives them a connection. Social recognition of a reality.

A person can for the first time understand why they are exceptionally capable in some areas and regularly collapse in apparently simpler situations. Autism therefore does not necessarily become a desired distinction. It can become the first explanation that does not break the person's life down into moral failures, lack of will or a confusing collection of individual disorders.

If this explanation is institutionally rejected, the person does not merely lose a diagnostic term. They lose a recognised order of their life.

They lose the claim to help within an experience of disability. Twenty-seven years of extensive unemployment are a massive experience of disability. Yet the concrete experience of disability was barely addressed in the Humboldt assessment. The question was not what disabled the author to such an extent that he had been almost completely unemployed for 27 years while still working 40 hours per

week on his special interest; rather, the clinic wanted to see whether a social deficit became as visibly obvious as possible within the rooms of the clinic.

This appears disproportionate to a degree that bypasses lived reality. As though a heterosexual psychologist attempted to identify a lesbian woman by showing her pictures of a naked man or a naked woman and measuring her pulse.

The lived reality plays no role whatsoever in the examination.

How ridiculous does the state, does the clinic, want to make itself here?

The Person Is Removed from the Category

Diagnostic identity erasure consists in a specific separation:

> *The person retains the experiences but is removed from the category through which these experiences became understandable and socially connectable.*

They may remain sensory-sensitive, overloaded and dependent on particular working conditions. But they are no longer regarded as autisticly sensory-sensitive, autisticly overloaded or autisticly disabled.

Their difficulties are instead assigned to other categories or treated as individual personality problems.

This has substantial practical consequences.

Without institutional recognition, the following may be absent:

- autism-specific counselling;
- accommodations;
- participation benefits;
- appropriate adaptations at work;
- a modified therapeutic approach;
- and social-law recognition of the underlying disability.

The person is not freed from the limitations. They are separated from the rights associated with the category.

Because autism (neurodivergence), similarly to homosexuality, is deeply connected with one's own experience of one's form of existence, this can become a form of administrative violence that causes massive harm. Research has shown that denial of diagnoses can have substantial consequences for autistic people.

Following Erving Goffman (1963), this can also be understood as an institutional reordering of social identity. Diagnostic categories do not merely describe characteristics; they influence under which socially readable identity a person appears and which of their experiences are treated as legitimate. In the present case, a desired label was not simply refused. The autistic explanation was replaced by other, partly more stigmatising readings. The person retained the same difficulties but now appeared institutionally under a different moral and clinical meaning.

Non-Diagnosis as an Active Intervention

A negative diagnosis is often understood by clinics as a mere omission: a particular diagnosis simply was not assigned.

In reality, it is an active intervention.

The finding changes:

- self-understanding;
- the future evidential position;
- access to benefits;
- credibility towards third parties;
- the interpretation of earlier and later crises;
- and the direction of further treatment.

In the present case, it also did not remain merely with the non-assignment of autism. The author received alternative descriptions, including dysthymia and a narcissistic personality accentuation.

There was therefore no diagnostic vacuum.

One identity was replaced by another institutional description of the person.

The author was no longer merely someone in whom autism had not been confirmed. His strong conviction in the value of his own research, his insistence on the autism hypothesis and his criticism could now be read within a personality-related framework.

The erasure was therefore simultaneously an overwriting. And this against the will of the person affected. Also against his experience of reality. This entails a massive responsibility that many clinics in practice do not wish to bear.

From Self-Knowledge to Self-Deception

Particularly serious is the implicit message that such a finding can carry.

The person may have researched for years, reordered memories, completed questionnaires, spoken with relatives and for the first time found a coherent explanation.

The negative feedback then does not merely say:

> *"Our criteria are insufficient for a diagnosis."*

It can be understood by the person as:

> *"Your entire self-knowledge was wrong."*

If a narcissistic accentuation is additionally documented, the message can intensify further:

> *"You were not merely mistaken. Your conviction that you understood yourself particularly well may itself be an expression of your personality problem."*

Self-knowledge thereby becomes potential self-deception.

The person loses not only institutional recognition of their model. Their very capacity to have developed this model becomes questionable.

It becomes ethically troubling if the alternative diagnosis primarily served the purpose of concealing resource scarcity and thereby erasing contradictions whose clarification would have required more effort than the clinic was willing to invest.

In other words, a person would have been stigmatised in order to polish the institution's own questionable performance record.

The Problem of the Missing Counter-Model and the Question of Actual Competence

Negative diagnosis would be less destructive if it offered a convincing alternative model.

This model would not merely have to name diagnostic concepts. It would have to explain:

- why the person experiences their life as autistic;
- why several autism-related instruments were elevated;
- how the long-term differences in functioning emerged;
- what causes the exhaustion and social overload;
- and what concrete support follows from this.

If such a model is absent, an epistemic vacuum emerges.

The previous explanation is withdrawn. The alternative does not carry the biography. The person remains with problems that once again appear disconnected.

In the author's case, partial categories were offered without producing a recognisably equivalent connection across his decades-long life and work structure.

This is a form of violence. If it rests on lack of care, it quickly becomes mistreatment.

One must also ask where the boundary between professional and ordinary citizen actually lies. How epistemically strong is this distinction in reality?

If a diagnostician explains that autistic burnout is actually dysthymia, meaning that the exhaustion results, for example, solely from the experience of poverty, and the author then thinks: but I always experience this when I meet people, whereas when I am alone I do not — at what point does objection become presumption towards the professional, and at what point is the person affected actually epistemically superior?

It is entirely conceivable that many aspects exist that are diagnostically relevant but can be judged better by the person experiencing them. A diagnostician does not inherently possess greater knowledge of an experience they themselves do not have because they may be neurotypical.

This case demonstrates the massive problem behind this. Is a self-assessment always more subjective than a professional one? Can the professional assessment actually be objective everywhere, meaning claim objectivity?

In practice, it frequently happens that a person's experience diverges strongly from a diagnostician's interpretation. This is often the basis of entire psychotherapies. But if the clinic has no procedure for dealing with this because time pressure is too great, how valid is the clinical assessment at all? Can the clinic actually claim to know better whether someone is autistic than an autistic person themselves?

This case raises substantial doubts.

Because in order to make this operationalisable at all, every question and every description would have to be integrated into a highly complex structure, and this could only occur participatively. Just because society and its institutions encounter a limit here does not mean that science does. It can find other answers here, and it should.

Otherwise, we do not escape a kind of colonisation of the human psyche. Self-determination must play a larger role. Also in diagnosis.

Self-Identification After Negative Assessment and the Question of AuDHD

A person receiving a negative finding faces an almost insoluble conflict.

If they give up their autistic self-identification, they may lose the model that explains their life best. If they retain it, they place themselves in opposition to institutional professional opinion.

The more strongly they defend this decision, the more readily they can appear diagnosis-fixated, lacking insight or influenced by social media.

A self-sealing structure thereby emerges again:

> *The person must defend their identity because it has been institutionally erased. Precisely this defence can subsequently be used as evidence that the identity is psychologically overvalued.*

A negative finding can therefore generate precisely the persistence that is later used against the person.

But this existential conflict is almost impossible for a human being to resolve.

A large part of neurodivergent experience resists representation. The transitions from ADHD to autism, the overlaps and the AuDHD profile are fluid, blurred and difficult to capture. Research knows that both ADHD and autism can be present simultaneously and that the probability is high.

But this requires appropriate handling within diagnosis. Overshadowing must be taken into account. One can no longer invoke ICD-10 today and behave as though the worldwide research debate on AuDHD did not exist, a debate showing a completely different autistic profile. Against this background, one cannot simply describe people as non-autistic when their profile looks massively like AuDHD. There is a clinical responsibility here.

Humboldt knew about this alternative model, but instead selected fragments that could in practice lead to further harm. This was scientifically dishonest.

When the author raised this problem with the diagnostician, she blocked the question. Humboldt was looking for a "pure autistic person". Even though it knew that such a person often does not exist.

But if masking and ADHD can obscure social deficits, why was this not addressed anywhere in the entire procedure? The author recognised this from the fact that no follow-up questions were asked. No differentiation took place in this field. ADHD was accepted as given, but there was not even a distinction between ADHD hyperfocus and autistic monotropism. A fundamental differential diagnosis did not take place in this domain. Particular questions would have had to be asked, such as:

> *"Do you easily fall into hyperfocus through distraction and pursue it for days, or do you, like the author, remain in the same deep tunnel for decades? — Is your interest characterised by a short-lived kick and enthusiasm, or by a long-term investigation of patterns?"*

This is not a complete assessment, but it would have been the minimum required to determine how far the author's neurodivergence extended. The author's wife had diagnosed ADHD. The two differed massively in everyday life. Precisely in those areas classically seen in AuDHD profiles.

With relatively "pure" ADHD, hyperfocus can be very intense, but is more often associated with novelty, urgency, emotional activation or changing areas of interest. In AuDHD, there can additionally exist an **attachment that remains stable over decades and organises identity and life**. Not merely: "I am strongly interested in this," but:

> *Without this object, I lose coherence, energy and access to myself.*

ADHD often produces forgetting, disorder, temporal disorganisation and difficulty maintaining routines. In AuDHD, there can simultaneously be a strong need for **internal order, coherence and predictable structure**. From the outside, this can appear contradictory:

- spontaneous and chaotic;
- but extremely rigid with certain procedures;
- frequently misplacing things;
- but organising important materials minutely;
- seeking variety;
- but barely tolerating interruptions of one's own thinking or work process.

The distinction would be: the author's partner could fail at maintaining order even though she wanted it. In the author, there appeared additionally to be a **personal, highly specific order** whose disruption directly produced loss of functioning.

ADHD can find routines boring and spontaneously seek novelty. Autistic structures, by contrast, may experience changes, unforeseen interventions or the interruption of an initiated process as profound loss of coherence. AuDHD can therefore appear paradoxical:

- self-initiated change: stimulating;
- externally initiated change: blocking or destructive;
- spontaneous new idea: welcome;
- unexpected interruption: barely tolerable.

The clinic should have examined all of this more closely. Then perhaps the difference would also have become clear that the author, as a human-rights activist active for decades, was driven by a strong reaction to general injustice, like many autistic people (Greta Thunberg, Julian Assange), but far less by

individually experienced injustice and narcissistic injury, for example. He did use such experiences as working material, as here too, but they were not the main drive. To recognise this, however, at least parts of his texts would have had to be read. Narcissistic injury does not ordinarily produce science and research and Critical Autism Studies. Why would anyone undertake all that effort if injured relationships rather than substantive matters were at the centre?

The cognition could have been understood better through differentiation at this and many other points, rather than merely observing facial expression and social behaviour.

The Cut-Off and the Identity Boundary

Identity erasure becomes particularly questionable in borderline cases.

If two people have very similar experiences, comparable life histories and almost identical test scores, but one lies just above and the other just below a threshold, their institutional life paths can diverge fundamentally.

The first receives a recognised identity and access to help. The second is regarded as non-autistic.

The cut-off thereby becomes not merely a diagnostic decision aid. It becomes an identity boundary.

This would only be ethically defensible if the boundary possessed correspondingly high certainty and if the real functional needs below the threshold were nevertheless recognised.

Where both are absent, classification produces an artificially hard rupture within what may be a continuous or methodologically uncertainly measured range.

The Experience Remains and Leads to a New Category of Autistic Person

At the end, the central paradox remains.

The institution can refuse the diagnostic term. It can formulate the finding so that autism is regarded as not confirmed or even as excluded. It can provide authorities, insurers and later treating professionals with a different description of the person. It can thereby alter social, medical and legal recognition.

Yet this constellation produces not only loss. It can also produce a new speaking position: the position of the **diagnostically rejected autistic person**. This does not mean arbitrary self-diagnosis, but rather a person whose autism was not recognised by an institution without the procedure having sufficiently refuted their biographical, functional and scientifically reflected autism hypothesis.

Such a person exists in a diagnostic intermediate space. They are neither clinically confirmed nor epistemically nullified by the negative judgement. Precisely this intermediate space can ground an independent political and scientific position. Anyone who continues to describe themselves as autistic after a methodologically limited or contradictory assessment is not merely contradicting a finding. They refuse to grant the clinic the right to derive from its non-confirmation a comprehensive authority over identity, belonging and legitimate self-description.

There is a human-rights dimension to this. Clinical institutions can decide which diagnoses they issue. It does not automatically follow that they possess a monopoly over the language through which people may describe their own experience, belonging and life history. Medical classification, social-law recognition, personal identity and political group belonging are connected, but they are not identical.

Continued autistic self-description can therefore also be an emancipatory act. It does not mean the abolition of clinical knowledge, but its de-monopolisation. Biographical self-knowledge, long-term functional history, perceptions by others, participatory research and knowledge from autistic communities stand alongside clinical assessment. Diagnosis does not thereby lose all meaning. It does, however, lose the claim to decide alone who is permitted to speak as an autistic person.

This position simultaneously possesses a solidaristic dimension. It can strengthen people who cannot obtain an assessment place, whose profile has been overlooked because of masking, age, comorbidity or unusual biographies, who have received contradictory findings, or who cannot afford an independent second opinion. The message is not that every diagnostic self-attribution is beyond challenge. It is that institutional non-recognition must not oblige people to deny their own experience when the diagnostic procedure itself does not transparently disclose its limitations and possible fallibility.

The diagnostically rejected autistic person is therefore not a contradiction in terms. It describes a person who has been excluded from a clinical category without this necessarily disproving the reality to which that category refers.

The following chapter examines what responsibility follows from this for diagnostic centres. For negative feedback can trigger severe crises in highly vulnerable people. The question is therefore not only whether the finding was professionally sufficiently justified, but what duties of protection and follow-up care an institution assumes when its judgement fundamentally destabilises a person's self-understanding, healthcare provision, legal position and sense of belonging.

20. Diagnostic Harm and the Duty of Safeguarding

A diagnostic institution bears responsibility not only for the formal correctness of its decision. It also bears responsibility for the foreseeable consequences of the procedure, particularly when it works with highly vulnerable people and the result has substantial effects on self-understanding, healthcare provision and legal participation.

This does not mean that a clinic would have to assign a diagnosis in order to avoid a crisis. Diagnostic integrity may also require a negative result. But precisely then the question arises of how this result is prepared, communicated, limited and followed up.

In the case examined, the author's particular vulnerability was known to the clinic. He had openly described severe exhaustion, long-standing institutional conflicts, material insecurity and the existential significance of the diagnosis. The clinic also knew that access to assessment had come about only after years and under conditions of extreme scarcity in healthcare provision. The finding could therefore not be treated as an ordinary medical communication.

Safeguarding Begins Before the Feedback

Safeguarding must not begin only when a person visibly collapses after the conversation.

It begins already with the planning of the procedure.

In a highly conflict-laden and vulnerable case, it should have been examined in advance:

- whether the clinic itself was even the appropriate and sufficiently independent institution;
- what risks a negative feedback carried;
- whether additional time was required for the conversation;
- whether a trusted person should be involved;
- how uncertainty could be communicated;
- and what concrete follow-up options existed in the event of a crisis.

Such preparation would not have constituted preferential treatment of the patient. It would have been an expression of professional responsibility for risk.

The Feedback Meeting as a Clinical High-Risk Moment

The feedback meeting was the point at which institutional power became maximally concentrated.

The diagnosticians already knew the result. The author did not. The institution possessed notes, the case conference and the finding. The author possessed only his own memory and the trust that his material had been adequately examined.

With the communication of the result, his position changed within a matter of minutes. A person who had hoped for recognition of a possible disability became a person whose central self-explanation was institutionally rejected and replaced by other categories.

Such a moment requires particular communicative care.

This includes:

- an understandable justification;
- sufficient time for questions;
- clear identification of remaining uncertainty;
- separation between non-confirmation and reliable exclusion;
- and recognition of the emotional significance of the result.

If these elements are absent, the feedback itself can become traumatising. The Humboldt University clinic deliberately set a short time window even though it knew what was to be expected. This can only be described here as grossly negligent.

The institution's self-protection stood far above the protection of the patient.

The Difference Between Disappointment and Injury

A negative diagnosis will inevitably be disappointing when a person had hoped for a different result. Not every disappointment is institutionally caused harm.

Injury arises, however, where in addition:

- the person's own evidence is not seriously addressed;
- the person experiences themselves as being laughed at or devalued;
- their perception is destabilised through contradictory messages;
- their objection can be interpreted in personality-related terms;
- and no sustainable support follows.

In the author's case, the burden therefore did not lie only in the fact that he did not receive the diagnosis he expected. It lay in the way the non-diagnosis was connected with institutional defensiveness, lack of transparency and morally burdened reinterpretation.

The Duty to Provide a Containment Structure

The more consequential a finding is, the less an institution may leave the person alone after communicating it.

An appropriate containment structure could include:

- a timely follow-up conversation;
- a written, understandable explanation of the weighting;
- the possibility of correcting factual errors;
- an independent second opinion;
- a crisis contact point;
- concrete referral;
- and recommendations oriented towards the actual functional problems irrespective of the diagnostic label.

In the case examined, such a structure was not recognisably available to a sufficient degree. The author received a finding, but no equivalent solution for the problems that continued to exist. He received alternative categories, but no recognisably sustainable pathway of care. He was referred to the possibility of making a complaint, but was not clinically contained.

The fact that he could contact the clinic again now encountered a massive problem of trust.

And he was told that under no circumstances would the finding be changed.

This is important because it fundamentally contradicts the reference to the possibility of complaint, meaning that it indicates that the author was simply being allowed to run into a wall.

Although the clinic knew what depended on the diagnosis for the author, it labelled the finding merely as an opinion that could continue to stand as an opinion even if facts contradicted that opinion.

This was the pinnacle of institutional self-protection regardless of losses.

Politics must not accept something like this. One of the leading university clinics in Germany must not invoke opinion. It must prove, or remain silent.

Humboldt treated the self-diagnosed person's account as subjective while itself engaging in speculation.

Responsibility Does Not End with the Report

A clinic might object that its task consists in diagnosis, not long-term treatment. This institutional limitation is understandable. It does not, however, release it from responsibility for foreseeable immediate consequences.

Anyone who makes an existentially significant decision must at least ensure that the person is not left after that decision without orientation and without accessible or still trustworthy support.

This is particularly important in autism assessment because those affected frequently already bring with them a long history of misunderstandings, misdiagnoses and institutional rejection.

The feedback meeting can therefore reactivate earlier injuries.

A new rejection is then not experienced as an isolated finding, but as the repetition of a pattern spanning decades:

> *Once again the person was not understood. Once again the institutional perspective took priority. Once again the experience remained without an adequate explanation.*

The Patient Must Not Become the Opponent

In the case examined, the clinical relationship was heavily burdened by the institutional history.

Precisely for this reason, the clinic should have taken particular care to continue treating the author as a patient even within the conflict.

This does not mean tolerating every sharp statement or agreeing with every criticism. It means not losing sight of vulnerability as soon as the person objects.

An institution is permitted to defend itself.

But in doing so, it must not forget that the person attacking it may simultaneously be harmed in their health by its decision. Clinical responsibility does not end where the person becomes inconvenient.

A diagnostician who simply ends such a heated conversation because she may have to go to the hairdresser shortly afterwards is not acceptable.

Safeguarding as Institutional Self-Limitation

Safeguarding does not require only care towards the patient. It requires self-limitation by the institution. The clinic must acknowledge:

- that its judgement is fallible;
- that its communication can cause harm;
- that its power is greater than that of the patient;
- and that a negative finding does not automatically end responsibility for what follows.

This recognition must be translated into procedures.

These include:

- clear escalation and follow-up plans;
- independent complaint pathways;
- protection against personality-related pathologisation of substantive criticism;
- and the possibility of having particularly conflict-laden cases reviewed externally.
-

The Ethical Minimum Requirement

The ethical minimum requirement is not that every crisis can be prevented.

It is:

> *A diagnostic institution must not make a foreseeably destabilising decision without simultaneously organising responsibility for its immediate consequences.*

In the present case, the impression emerged that the clinic regarded the diagnostic decision as concluded while the psychological and social consequences remained entirely with the author.

The institution closed the case. For the author, a new crisis began.

Those who are diagnostically excluded are not only absent from healthcare provision. These people are also absent from the scientific populations through which autism is described and diagnostic instruments are further developed. Diagnosis can thereby continuously reproduce its own blind spots.

21. The Production of Diagnostic Populations (Looping Effects)

Diagnosis does not only decide which individual person receives an autism diagnosis.

It also determines who becomes visible as autistic at all within healthcare, clinical statistics and scientific studies.

Diagnosis therefore does not merely describe.

It produces the population that later serves as the basis for further research.

Before the assessment, the author was asked whether he would be willing to participate in further studies in the service of research. He was entered into the corresponding pool and was indeed contacted shortly afterwards about the first study. He had therefore already been integrated as a subject of research interest.

This connection is particularly important because diagnostic instruments and clinical models are frequently developed, tested and further refined on the basis of already diagnosed groups. Those who are not recognised by the existing procedures are therefore absent from precisely those datasets from which future conceptions of autism emerge.

A recursive selection loop can thereby arise:

> *Diagnostic procedures preferentially recognise those profiles to which they are already adapted. The people recognised subsequently form the research group on the basis of which the same procedures are confirmed and further developed.*

What lies outside the filter remains scientifically underrepresented.

It must not be forgotten that the Humboldt clinic was in a conflict of interest here because it itself uses diagnoses made within its own institution for research in its own studies.

This process recalls Ian Hacking's (1986) work on *making up people* and on the looping effects of human classifications. Diagnostic categories do not merely neutrally depict their objects. They structure who is recognised as belonging to a group, how people understand themselves and which population is subsequently studied scientifically. In the present context, the looping effect already lies in the selection itself: diagnostically recognised autistic people shape the clinical image of autism, while rejected profiles disappear from the population and further confirm its apparent homogeneity.

Diagnosis as an Entry Ticket into Research

Many studies on autism rely on clinically diagnosed participants. Methodologically, this is initially understandable. Research requires criteria through which it can determine who belongs to the group under investigation.

Diagnosis thereby becomes the entry ticket into the scientific population.

People who do not receive a diagnosis because of masking, high verbal competence, missing childhood data, comorbidities or unusual life histories do not appear in such studies as possibly false-negative autistic people.

They appear as non-autistic people, as people with other diagnoses, or not at all. Their experiences therefore do not enter into the description of what autism can look like.

The Selected Norm

If particular profiles are diagnosed more frequently, their characteristics can gradually come to appear as the typical or central form of autism.

These may include:

- clearly visible social abnormalities;
- limited ability to compensate for social difficulties;
- clearly recognisable repetitive behaviours;

- early documented developmental differences;
- and special interests that are diagnostically easy to name.

Profiles that fit this form less clearly are diagnosed less frequently.

As a result, they are again absent from research and clinical training. The diagnostic norm confirms itself. What is recognised well is regarded as typical.

What is recognised poorly is regarded as rare, atypical or possibly non-autistic.

The frequency of a profile in clinical samples may therefore say less about its actual prevalence than about its institutional recognisability.

The Exclusion of Complex Adults

Adults diagnosed late with complex life histories are particularly at risk.

In them, autistic characteristics can overlap with decades of adaptation, ADHD, depression, anxiety, trauma, poverty and institutional conflict.

The original profile is no longer visible in a "pure" form.

The person has developed strategies, avoided particular situations, learned skills and organised life around their own limits.

Precisely this adaptation can result in them appearing clinically less unequivocal. If they are excluded, what disappears from research is not simply some marginal case.

What may disappear is precisely the group that could show particularly much about how autism changes over decades, becomes masked and produces secondary illnesses under social pressure.

The False-Negative Result Disappears Statistically

A false-positive finding may later become visible. The person may not fit the expected group, may receive a different assessment or may appear as an atypical case in studies.

A false-negative finding disappears more easily.

The person is not included in the autism population.

There is often no later procedure that systematically checks whether the exclusion was correct. They remain within other diagnoses, in self-help groups, in unsuccessful therapies or outside healthcare altogether.

Statistically, they are simply regarded as non-autistic.

The actual rate of false-negative decisions can therefore remain almost invisible. The system primarily counts its confirmed diagnoses. It does not reliably count those who may have been wrongly excluded.

Research Confirms Clinical Selection

A closed loop can arise from this structure:

1. Clinical procedures preferentially recognise particular profiles.
2. These people are classified as autistic.
3. Research predominantly studies this diagnosed group.
4. The characteristics derived from it shape new instruments and guiding models.
5. Future diagnosis increasingly searches for the same characteristics.
6. Divergent profiles are again recognised less frequently.

Clinical selection subsequently appears as scientific confirmation.

In reality, research may partly reproduce the preceding selection performed by diagnosis. This does not mean that the resulting data are worthless. They may accurately describe the group examined.

The problem lies in the tacit generalisation:

> *What frequently occurs among those diagnostically recognised becomes what autism is fundamentally supposed to be recognised by.*

The Invisible Counterexamples

The author's case makes visible what kind of evidence can be lost within such a loop.

A person may:

- have very high autism-related screening scores;
- be assessed as strongly conspicuous by a close reference person;
- display an extraordinarily stable and intense attachment to a body of work;
- be barely able to maintain social and occupational participation over decades;
- simultaneously appear verbally differentiated and reciprocal in one-to-one conversation;
- and remain below the ADOS cut-off.

If such a person is classified as non-autistic, they may appear in future research as a counterexample to the significance of their own characteristics.

High screening scores can then be treated as unspecific. Masking appears difficult to objectify. The attachment to the body of work does not count as a special interest. Situational social competence receives greater weight.

What may have been a false-negative autism case can thereby indirectly stabilise the criteria that excluded it.

The Production of "Non-Autistic People"

Diagnosis does not only produce autistic people as an institutional category.

It also produces non-autistic people.

This second group, however, is not necessarily homogeneous.

It can contain:

- genuinely non-autistic people;
- people with individual autistic characteristics;
- people with the broader autistic phenotype;
- false-negative cases;
- strongly masking autistic people;
- people with insufficient developmental histories;
- and people whose comorbidities obscure the diagnostic picture.

If all of these people are simply combined under "no autism", an artificially uniform comparison group is produced.

The categorical boundary in the finding can then suggest scientific clarity that does not exist in the underlying population.

The Pathologised Exclusion Group

It is particularly problematic that excluded people not infrequently receive other diagnoses. They therefore do not simply disappear from autism research.

They may appear in studies of depression, anxiety, personality disorders, somatic complaints or chronic exhaustion.

Autistic characteristics may there be interpreted as accompanying features of these diagnoses. A potentially unrecognised autistic population is thereby distributed across other clinical groups.

Autism research loses their experiences.

Other research fields receive them under a different classification. This can produce mutual distortion:

Autism appears more homogeneous than it actually is.

Other diagnoses appear associated with characteristics that may in part arise from unrecognised autism.

The Role of Personality-Related Diagnoses

Personality diagnoses have particular significance within this selection structure.

If direct communication, persistence, strong self-knowledge and conflicts with institutions are read as narcissistic, compulsive or other personality traits, possible autistic profiles are not merely excluded.

They receive an alternative explanation that can make later return to autism assessment more difficult.

A future team no longer sees an open question. It sees an already documented personality problem.

The earlier exclusion thereby becomes a precondition of later perception. The file learns from itself.

The Self-Confirming File

Medical and administrative documentation creates temporal continuity.

A finding once recorded can be adopted by later institutions. New observations are interpreted in the light of the existing file.

If the person objects again, this can fit the existing personality picture.

If they request another autism assessment, they may appear diagnosis-fixated.

If they refer to earlier errors, they may be regarded as lacking insight or conflict-prone.

A self-confirming documentation loop thereby emerges. The original possible error is not independently reviewed. It structures the conditions under which every later review takes place.

Diagnostic Populations Are Not Natural Populations

From a scientific perspective, the following is therefore decisive:

> *A clinically diagnosed autism population is not identical with the totality of all autistic people.*

It is a population selected through criteria, instruments, resources, access pathways and institutional expectations.

Only those who first manage to obtain an assessment place can enter it at all.

The person must then pass through the procedure in a way that produces enough codable evidence.

Access itself already filters according to:

- geographical proximity;
- knowledge of the healthcare system;
- organisational ability;
- endurance;
- support from others;
- financial resources;
- and psychological stability during long waiting periods.

The diagnostic procedure adds a second filter. Research recruitment often produces a third.

What ultimately appears as the scientific autism population is therefore the product of several successive selections.

The Double Exclusion

In the preceding investigation, the author showed how 1,667 people competed for approximately 25 places. Most of those affected were excluded before any professional assessment took place.

Anyone who receives a place has therefore merely overcome the first filter.

Within the diagnostic procedure, the second follows:

Is the concrete profile recognised by the available instruments and clinical model?

A double exclusion thereby arises:

> *First, people are excluded from diagnosis. Then those who nevertheless gain access can be excluded from the diagnostic category.*

Both groups are later absent from research and healthcare. The first group was never examined. The second was examined but classified as non-autistic. Science can hardly distinguish between them.

The Debate About Overdiagnosis

The current debate about autism assessment frequently focuses on possible overdiagnosis, social media, self-diagnosis and people who supposedly insist on a desired diagnosis.

The present study places the often-described outrage of rejected people and their demand for an autism diagnosis into a completely different perspective.

A scientifically balanced debate must simultaneously ask:

- How many people are diagnosed false-positive?
- How many are excluded false-negative?
- Which profiles are affected by which error?
- What role do gender, age, intelligence, language, masking and comorbidity play?
- Which errors are favoured by resource scarcity?
- And which errors remain statistically invisible?

Overdiagnosis and underdiagnosis are not opposites of which only one can exist. A system can over-recognise particular profiles and systematically under-recognise others.

If so many people are convinced that they are autistic, we should seriously ask whether a different population within what we call autism is becoming visible here. If their life experiences overlap so strongly with what we describe as autism, if the distress and the resulting harms are so massive, and if alternative explanations simply do not fit, then these people cannot simply be thrown out onto the street as though everything were mere hysteria. The question must be clarified as to what lies behind this clinical picture. Precisely because what autism is has changed continually over time, including AuDHD and other profiles, clinical practice cannot retreat into ignorance and contempt for people behind outdated standards such as ICD-10.

Research has an ethical duty, when making determining statements, to exercise corresponding care, which does not happen in many clinics.

If public debate then turns into hostility against self-diagnosed autistic people, a massive harm threatens that research may painfully regret in ten or twenty years, just as it now regrets the accusation against “refrigerator mothers”.

Nobody can say that they did not know, that they could not have seen the problem.

Instead of spending millions searching for a cure for autism, it might be more appropriate to investigate what is actually going on with those rejected people who demand an autism diagnosis. The procedure shown here is nowhere near sufficient to answer this question adequately. Yet it is frequently used to stigmatise precisely this group.

The Moral Asymmetry of the Debate

The moral distribution of suspicion is also remarkable.

Self-identified people are frequently asked whether they are mistaken, whether they are seeking a label, or whether social media has distorted their perception. Diagnostic institutions are less frequently asked with the same severity whether their procedures systematically fail to recognise particular profiles.

The possible self-deception of the patient is personalised. The possible misclassification by the institution appears as an unavoidable methodological side effect.

The problem of error is therefore distributed asymmetrically here too. The individual person can become an impostor. The institution remains a professional authority despite possible systematic exclusions.

Participatory Research as a Corrective

One possible corrective lies in participatory research.

"Nothing About Us Without Us" means in this context that not only already clinically diagnosed autistic people should be involved in developing research and diagnosis.

People with:

- late diagnosis;
- contradictory findings;
- negative diagnostic experiences;
- strong self-identification;
- multiple misdiagnoses;
- and unusual histories of compensation

must also be included as relevant sources of knowledge.

Rejected people in particular can provide indications of where procedures fail. Their complaints are not merely disruptions of clinical processes. They can contain data about the selection limits of diagnosis.

Research on Those Rejected

A central blind spot lies in the fact that there is little systematic investigation of what happens in the long term to people who receive a negative diagnosis despite high autism-related scores.

Studies are needed that ask:

- Which diagnoses do these people receive later?
- How do their health and functioning develop?
- How many nevertheless receive an autism diagnosis on independent reassessment?
- Which characteristics distinguish them from cases confirmed early?
- What role did masking and missing childhood data play?
- What effects did the negative feedback have?
- And how often did personality-related alternative diagnoses later prove incorrect or insufficient?

Without such research, the quality of negative diagnoses can hardly be assessed. A system that studies only its confirmed cases does not know its own exclusion-error rate.

Negative Diagnosis Requires Follow-Up

From this perspective, a negative finding would not necessarily constitute the final closure of a case.

In complex and contradictory constellations, follow-up could be provided:

- renewed assessment after a particular period;
- independent second evaluation;
- examination of additional biographical evidence;
- observation of the effects of recommended treatments;
- and reassessment if the alternative model fails to explain the functional problems.

Diagnosis would thereby be understood as a process capable of learning.

At present, by contrast, the negative finding can remain institutionally stable even if the treatments chosen afterwards fail and the original explanatory problem persists.

Research Produces Its Own Blind Spot

The core of the problem can be summarised as follows:

> *If diagnostic procedures systematically recognise particular autistic people less well, precisely these people are absent from the data through which the procedures are later judged scientifically adequate.*

The blind spot thereby remains blind. It can even grow. Diagnostically recognised profiles are described with ever greater precision.

Excluded profiles appear as diagnostic borderline cases, comorbidities, personality problems or misguided self-diagnoses.

Research improves precision within the selected population. It does not necessarily improve reach beyond that population.

The Significance of the Present Case

The case examined cannot by itself prove the existence of systematic selection bias.

It does, however, show by example how such distortion can arise:

- A highly complex older adult reaches assessment after extreme barriers to access.
- Extensive long-term evidence can only be absorbed to a limited degree.
- Direct observation and clinical interpretation receive high weight.
- Standardised autism-related abnormalities are relativised through other diagnoses.
- A possible special interest is not recognised.
- Objection can be read in personality-related terms.
- The person is classified as non-autistic.
- Their data thereby leave the autism population.

The case subsequently does not become an example of possible diagnostic limitation. It becomes a non-autism case. Precisely this transformation is scientifically relevant.

The Specialist Clinic as Producer of Its Own Research Object

For Humboldt University, this problem of selection has particular significance. It is not coincidental that the institution is called the **Special Outpatient Clinic for Social Interaction**. It is institutionally closely connected with the research group *Clinical Psychology of Social Interaction* led by Prof. Dr Isabel Dziobek. The official research focus lies on the bio-psycho-social mechanisms of social interaction and their disorders; in Dziobek's research, social cognition, emotion recognition, understanding of mental states and observable interaction behaviour, among other things, play central roles.

Precisely from this arises a methodological tension. A clinic whose clinical and scientific identity is strongly oriented towards social interaction may tend to recognise autism most reliably where it becomes clearly observable in this dimension and can be captured through the social-cognitive models being used. This does not mean that other domains are fundamentally ignored or that a particular diagnosis is deliberately prevented. It does, however, raise the question of whether long-term attachment structures, monotropism, *Eigenzeit*, the costs of learned compensation and unusual forms of highly developed social performance receive the same weight within this research framework as directly observable social reciprocity.

The present case is particularly problematic for precisely this reason. If many people with a similar profile — highly verbally competent, socially reciprocal in structured one-to-one conversations, strongly masking, yet severely impaired in functioning over decades and bound to an unusually narrow life and work structure — were admitted into the diagnosed autism population, this could challenge the theoretical emphasis of the clinic. Such a population would be less clearly characterised by visible deficits in social interaction. It would show more strongly that social competence can be situationally learned, performatively produced and associated with substantial costs, while the actual autistic connection may emerge more clearly in forms of attachment, organisation of life and long-term context dependence.

This is not evidence of conscious selection by Prof. Dziobek or her clinic. It does, however, reveal a fundamental problem of clinically adjacent research: the institution diagnoses the people who later form its autism population and subsequently studies within that population those characteristics that already received particular weight during diagnostic selection. If social interaction is strongly weighted, people with clearly visible abnormalities in this domain may preferentially enter the group. If research then identifies pronounced differences in social cognition or interaction, this can appear as confirmation of the initial model even though the population was partly selected according to precisely that model beforehand.

The clinic would therefore not merely be an observer of an already given autism population. It would participate in producing it.

For Prof. Dziobek's work, this generates a particularly important critical question:

> *To what extent do the populations examined at the specialist clinic describe autism itself, and to what extent do they reflect the social-interactional orientation of the institution that decides who is admitted to this population as autistic?*

This question is not directed against the legitimacy of social-cognitive research. Research into social interaction has produced important findings and therapeutic approaches; the research group explicitly develops diagnostic and therapeutic procedures for autistic adults. Precisely for this reason, however, it must take seriously the possibility that its clinical access recognises some presentations of autism better than others.

The author's case could here be understood as a **negative borderline case of the research model**. He embodied numerous social and biographical difficulties but did not show the expected degree of observable social abnormality within the diagnostic space. His inclusion in the autism population would therefore not merely have concerned the diagnosis of an individual person. It would have raised the question of whether the theoretical concentration on social interaction, in certain complex adults, overlooks precisely what it claims to explain.

If such a case is excluded, the existing model remains comparatively stable.

If it is included, the model may need to be expanded. Then software financed through third-party funding and developed within the clinic to improve diagnosis might no longer appear quite so accurate.

Precisely for this reason, the diagnostic decision must not remain completely dependent on the theoretical perspective whose reach the case itself is testing. Otherwise, there is a risk that the specialist clinic clinically reproduces its own scientific premise: it preferentially recognises as autism what is already readable as autistic within its theory of social interaction and classifies what is difficult to integrate outside the population.

The case does not prove that this happens systematically at Humboldt. It does, however, make visible why the diagnostically excluded group should be just as relevant to Prof. Dziobek's research as the diagnostically confirmed group. Precisely people like the author could show where the social-interactional perspective reaches its limits, which autistic structures it does not adequately capture, and to what extent the clinic, through its diagnosis, produces the object that its research subsequently describes.

An even more fundamental question is whether the clinic actually selects autism at all, or primarily those forms of social abnormality that count as autistic within its theoretical model. If diagnosis primarily evaluates observable social reciprocity and interaction while monotropic attention, Hyper-Systemizing, long-term special interests and other forms of autistic information processing play a lesser diagnostic role, then the resulting population may not describe autism as a whole, but rather that form of autism that becomes particularly visible under these theoretical premises.

Perhaps the actual challenge of autism assessment no longer lies primarily in the clinical recognition of psychological symptoms, but in understanding neurodivergent cognition. The question would then arise in the longer term whether clinicians alone are the appropriate experts for assessing complex autism profiles, or whether diagnostic procedures must in future be shaped far more strongly by findings from cognitive science, neurodiversity research and participatory research.

Different Theoretical Weightings in the International Field

It must be taken into account that autism assessment internationally is by no means based on a single theoretical model. In Germany, a clinical tradition remains influential that describes autism primarily through impairments in social communication, social reciprocity and Theory of Mind. The German S3 guideline on autism diagnosis was also clearly oriented towards these classical core domains and observable deficits.

Alongside this, more relational and experience-oriented models have become established in international research. The **Double Empathy Problem** understands misunderstandings between autistic and non-autistic people not solely as a deficit of the autistic person, but as a reciprocal difficulty between groups that perceive and communicate differently. Empirical studies show that non-autistic people also understand autistic people less accurately and that social connection between autistic people can in some cases function better than in mixed interactions.

The author has also published extensively in this field.

Monotropism shifts attention even more strongly away from a primary social deficit and towards the organisation of attention and attachment. It describes the concentration of limited attentional resources on a small number of intensely interconnected channels of interest and action and can thereby explain difficulties with switching, interruptions, competing demands and social ambiguity. The model was explicitly formulated as an alternative explanation of diagnostic autism characteristics as early as 2005, but remains far less firmly embedded in clinical routines than social-cognitive models.

These differences must not lead to the simplistic claim that Germany completely ignores Double Empathy and monotropism while the rest of the international research field has already adopted them uniformly. Theory-of-Mind models remain influential internationally as well, and both Double Empathy and monotropism continue to be scientifically tested and controversially discussed. What matters, rather, is the differing **weighting**: if social difficulty is viewed primarily as an individual deficit, visible reciprocity and clinical interaction receive particular weight. If it is understood relationally or in terms of attention, context, fit, attachment structure, compensation and the costs of social performance become more important.

It is nevertheless striking that autistic people appearing in the media internationally often appear far less conspicuous than German autistic people. This is also connected with media selection bias, but perhaps not only that.

For the present case, this difference is central. Within a strongly social-deficit-oriented model, the author's situationally successful interaction could speak against autism. Within a Double Empathy and monotropism model, the same situation could be read differently: as learned social performance within a structured setting, while the actual autistic structure became more visible in long-term attachment, context dependence, problems with switching and the repeated collision of different orders of relevance. The diagnostic decision may therefore have depended not only on the available data, but also on which autism model determined what was allowed to count as central within those data.

The Central Research Question

The overarching research question is therefore:

> *To what extent does the clinically diagnosed autism population actually describe autism — and to what extent does it describe the capacity of existing institutions to recognise particular forms of autism?*

This question is not directed against clinical research.

It demands an expansion of its object.

Autism research must not examine only those who successfully passed through the diagnostic filter.

It must also examine the filter itself.

This includes:

- those rejected;
- borderline cases;
- those later diagnosed differently;
- strong maskers;
- unusual life histories;
- and those who continue to report autistic experience after a negative diagnosis.

Only then can it be clarified whether diagnosis recognises an existing population or produces its own population.

The preceding chapters have therefore reconstructed the path from the individual assessment to the scientific reproduction of the filter. The following section must derive concrete minimum standards from this: How would a participatory, transparent and error-sensitive adult autism assessment have to be designed so that it no longer presents its own selection limits as truth about the person?

22. Minimum Standards for Participatory and Error-Sensitive Adult Autism Assessment

The preceding chapters do not lead to the demand that clinical diagnosis be replaced by self-assessment. Nor does it follow that every person who understands themselves as autistic should automatically receive a formal diagnosis.

The central demand is more limited and at the same time more demanding:

> *Adult autism assessment must methodologically take into account its own fallibility, its selection conditions and the consequences of its power.*

Particularly in people diagnosed late, who compensate strongly and have biographically complex histories, it is not sufficient to conduct standardised procedures correctly and then refer to a clinical overall assessment. A scientifically robust procedure must make visible how contradictory evidence was weighted, which data could not be sufficiently incorporated, and how remaining uncertainty was handled.

The present case suggests several minimum standards for this. They are not intended to replace clinical judgement, but to increase its traceability, corrigibility and ethical legitimacy.

22.1 Transparency About Institutional Conflicts

Before assessment begins, it must be disclosed if a prior conflict exists between the person being assessed and the diagnosing institution.

This includes in particular:

- lawsuits;
- complaints;
- public criticism;
- ongoing research or media processes;
- prior personal involvement of the leadership;
- and internal communication about the person concerned.

The decisive question is not only whether conscious bias can be proven. What matters is whether there is a foreseeable risk of distorted perception or of the appearance of insufficient independence.

In such cases, it should be examined whether the assessment can be carried out by another institution or at least by an institutionally independent team. If this is not possible, the safeguards must be transparently documented.

Neutrality must not merely be asserted.

It must be procedurally produced.

22.2 Separation Between Non-Confirmation and Exclusion

A particularly important minimum standard concerns the language of negative findings.

A clear distinction must be made between:

The diagnostic criteria could not be sufficiently confirmed.

and:

Autism is not present.

The first statement describes the result of a concrete procedure.

The second makes a comprehensive claim about the person.

Reliable exclusion presupposes that the procedure used was capable of capturing the concrete profile with sufficient reliability and that the substantial counter-evidence was explained in a traceable manner. If this is not technically possible or cannot be achieved within the health insurer's budget, this must be made transparent.

Where masking, high compensation, missing developmental data, contradictory test scores or long-term evidence that cannot be adequately examined are present, this uncertainty must remain visible in the finding.

Clinical integrity is not demonstrated by maximum certainty. It is demonstrated by the precise limitation of what can actually be known.

22.3 Long-Term Biographical Evidence as an Independent Data Source

In older adults, life history must not be treated merely as background information.

It is a central part of the assessment.

The longer a person has lived with a possible neurodevelopmental profile, the more strongly it must be examined:

- under which conditions functioning was possible;
- which contexts repeatedly failed;
- which adaptation strategies were developed;
- how interests and attachments behaved across decades;
- what costs social compensation caused;
- and which secondary disorders emerged.

The clinical snapshot can supplement this long-term structure.

It cannot simply overwrite it.

Particularly important here is the distinction between visible ability and functional sustainability. A person may appear socially competent in a structured testing situation and nevertheless be permanently and substantially impaired outside this setting.

22.4 Structured Incorporation of Extensive Evidence

A clinic cannot be required to read several thousand pages in full.

It must, however, possess a procedure through which extensive evidence can be incorporated in an ordered way.

This could include:

- a structured summary submitted in advance;
- a selection of central biographical documents;
- a chronological timeline;
- an overview of recurring functional patterns;
- and an explanation of why particular materials are diagnostically relevant.

The institution would then have to disclose:

- which materials were examined;
- which were considered only in excerpts;
- which could not be examined;
- and what limitation this creates for diagnostic certainty.

Unread evidence must not be treated as though it had been examined and rejected.

22.5 The Diagnostic Evidence Matrix

In complex and contradictory cases, a diagnostic evidence matrix should become part of the documentation.

For each core domain, it should contain at least:

Domain	Evidence For	Evidence Against	Limitations	Alternative Explanation	Weighting	Residual Uncertainty
Social communication	Long-term problems, masking, informant assessment	Situationally good reciprocity	Artificial setting, high compensation	Social anxiety, ADHD	Reasoned	Open
Repetitive and bound structures	Intense attachment to the body of work, transition problems	Few visible stereotyped characteristics	Long-term evidence only partly examined	Vocation, hyperfocus	Reasoned	Open
Developmental course	Stable biographical patterns	Missing early documents	Age, loss of sources	Later development of burden	Reasoned	Open

such a matrix does not decide the diagnosis mechanically.

But it prevents the overall assessment from becoming an unreviewable concluding formula. It forces the procedure to make visible which data were actually compared with one another.

22.6 Right of Correction Before the Finding Is Finalised

Participation does not mean that the patient determines the result.

It does mean, however, that central misunderstandings can be corrected before they condense into a completed judgement.

Before the final case conference or release of the finding, the person being assessed should therefore receive at least a brief summary of the central anamnesic conclusions.

For example:

- Which main problems were understood?
- Which long-term patterns were assumed?
- Which alternative explanations are being examined?
- Which statements were interpreted as particularly diagnostically relevant?

The person could then mark factual errors, reductions or losses of context. The diagnostic decision would remain with the professional institution. But it would rest on a factually checked basis. Objection must not become possible only after its diagnostic meaning has already been fixed and corrections are no longer possible, meaning, as at Humboldt, simply rejected.

22.7 Symmetrical Error Sensitivity

All forms of knowledge involved are fallible.

These include:

- self-report;
- informant history;
- questionnaire;
- ADOS;
- clinical interview;
- observation;
- case conference;
- and overall assessment.

An error-sensitive diagnostic process must not search only for distortions on the patient's side. It must also identify possible clinical sources of error:

- confirmation bias;
- theoretical preconceptions;
- time pressure;

- reduction in note-taking;
- classism;
- institutional defensiveness;
- overweighting of social performance;
- and insufficient knowledge of more recent autism models.

Possible self-deception by the person being assessed is diagnostically relevant. Possible self-confirmation by the institution is equally relevant.

22.8 Separation of Primary Structure, Comorbidity and Secondary Disorder

Anxiety, depression, exhaustion and ADHD must neither automatically be treated as evidence for autism nor automatically as arguments against it.

It must be examined:

- Which characteristics were present first?
- Which developed later?
- Which may be secondary consequences of chronic overload?
- Which exist independently?
- Which model best explains the temporal development?

A differential-diagnostic alternative must do more than distribute individual phenomena across several categories. It must show why these categories together explain the life structure better. In particular, a consequence of remaining unrecognised must not become evidence of non-existence.

22.9 Special Burden of Justification for Personality Diagnoses

Personality-related attributions have a particular moral and institutional effect. They can influence a person's credibility over the long term and make later complaints appear symptomatic.

For this reason, they must be derived with particular care.

Necessary would be:

- several examples across contexts;
- long-term stability;
- exclusion of situational conflict dynamics;
- examination of alternative neurodivergent explanations;
- and clear separation between substantive objection and personality-related reaction.

Individual statements about recognition, envy, self-worth or the significance of one's own work are insufficient if their biographical and social context is not taken into account. The more strongly a diagnosis changes the moral perception of a person, the greater the required density of evidence.

22.10 Protection Against Self-Sealing Interpretations

A diagnostic model must, in principle, remain corrigible.

It must not be constructed in such a way that every possible reaction confirms its correctness. A methodological distinction must therefore be made between:

the content of an objection

and:

the manner in which that objection is expressed.

The substantive objection must be examined first.

Only afterwards may its communicative form be interpreted diagnostically. Otherwise, a possible error can be stabilised through the reaction to that error. A diagnosis must not become true because the person concerned defends themselves against it.

22.11 Recognition of Different Autism Models

A contemporary adult autism assessment must not remain restricted exclusively to a social-deficit-oriented model.

It should examine different theoretical perspectives:

- classical models of social communication;
- Theory of Mind;
- Double Empathy;
- monotropism;
- masking and compensation;
- sensory and attention-related models;
- and long-term structures of attachment and context.

These models do not have to receive equal weight.

But it must be visible which model determines the diagnostic gaze.

Particularly in cases where social interaction works situationally while severe functional problems exist biographically, an exclusively socially observational perspective may miss substantial data. This must not depend on the style or theoretical orientation of the particular clinic.

22.12 Support According to Functional Profile

Healthcare provision must not depend entirely on a categorical label.

Even when autism cannot be confirmed, substantial limitations may exist.

The assessment should therefore record, independently of the final code:

- which burdens are demonstrated;
- which environmental adaptations appear appropriate;
- which working conditions are sustainable;
- which communicative supports are needed;
- and which burdens should be avoided.

A person must not remain without appropriate support simply because their profile could not be diagnostically classified with certainty. Uncertainty about the category does not mean uncertainty about the need for support.

Neurodivergence must here be treated as a basic category within which overlaps exist. These do not always have to lead to a dual diagnosis of ADHD and autism, but they must not ignore the fact that such overlaps exist and that a strongly autistic person with ADHD cannot simply be treated like someone with ADHD alone.

AuDHD must also be allowed to play a role in its own particularities, without — or precisely in order not to — overlook overshadowing.

22.13 Independent Second Opinion in Cases of Contradictory Evidence

Where findings diverge strongly, an independent second assessment should be provided.

This concerns particularly constellations with:

- high screening scores;
- conspicuous informant history;
- low ADOS;
- plausible masking history;
- complex comorbidity;
- missing childhood data;
- and substantial biographical functional problems.

A second opinion must not merely be recommended theoretically. It must be practically accessible.

Under conditions of years-long waiting lists, merely telling the person that they can present themselves elsewhere again is not a real safeguard.

22.14 Follow-Up of Negative Borderline Cases

Negative assessment in complex borderline cases should not necessarily be understood as the final closure of a case.

Follow-up could examine:

- whether the alternative model works therapeutically;
- whether the functional problems become more understandable through it;
- whether new biographical data emerge;

- whether previous assumptions prove incorrect;
- and whether renewed diagnostic examination becomes necessary.

A system that never reviews negative decisions cannot know its false-negative rate. Error sensitivity therefore requires institutional capacity to learn.

22.15 Safeguarding and Crisis Follow-Up

Foreseeably destabilising feedback must be prepared.

This includes:

- sufficient conversation time;
- clear communication of uncertainty;
- a prompt follow-up conversation;
- crisis contacts;
- referral;
- and a concrete perspective for the next steps.

The institution must not discharge a highly vulnerable person with an existentially consequential result without clarifying how the immediate consequences will be contained.

The case does not end where the report is signed.

22.16 Research With Those Rejected

Finally, the quality of diagnosis must be investigated through the excluded cases.

Systematic studies are needed on people who receive a negative diagnosis despite high autism-related evidence.

It should be examined:

- How often is an autism diagnosis nevertheless made later?
- Which alternative diagnoses were assigned?
- What health consequences did the exclusion have?
- Which profiles were particularly frequently affected?
- Which instruments retrospectively proved misleading?
- And what roles did masking, age, giftedness and comorbidity play?

The rejected person is not merely a closed non-case.

They are a possible source of knowledge about the limits of the procedure.

From Participatory Diagnosis to Shared Epistemic Responsibility

The principle "Nothing About Us Without Us" requires neither the abolition of clinical expertise nor a veto right for the person being assessed.

It requires a different distribution of epistemic responsibility.

The professional contributes clinical experience, comparative knowledge and methodological competence.

The person being assessed contributes long-term knowledge of their experience, compensation and functional conditions.

Informants contribute observed everyday experience. Standardised instruments contribute comparability. Scientific research contributes knowledge about limitations, error rates and alternative models. None of these levels is sufficient on its own.

A participatory diagnostic process organises their relationship in such a way that no source becomes merely a supplier of raw data and no other becomes an invisible authority of truth.

The Minimum Standard of Scientific Integrity

An error-sensitive diagnostic process does not have to be infallible.

It must be able to show:

- what it knew;
- what it did not know;
- which evidence it examined;
- which evidence it could not examine;
- how it weighted contradictions;
- which alternative model it adopted;
- and which uncertainty remained.

The minimum standard is therefore:

> *The more consequential the judgement, the more traceable its epistemic path must be.*

The investigation so far suggests that precisely this transition from evidence to judgement was insufficiently transparent in the procedure examined.

The concluding chapter brings these findings together. The issue is not an asserted right of the author to a particular diagnosis. It is the right of every person to a diagnostic process that knows its own limits, provides reviewable reasons for its decisions and does not shift the consequences of its possible errors entirely onto those affected.

Not every diagnostic borderline case can be adequately clarified within the routines of clinical healthcare. Where decades of biographical evidence, extensive documentation of a body of work, high compensation, comorbidity and contradictory diagnostic data converge, repeating the same standardised procedure may merely reproduce the same epistemic bottleneck. In such cases,

interdisciplinary, participatory and open-ended case research should be considered, integrating clinical, biographical, work-related and institutional evidence according to transparent criteria. Its aim would not be to confirm a desired diagnosis, but to examine which explanatory model best carries the totality of the available data and what limitations the existing diagnostic instruments possess.

23. Conclusion: Not the Right to a Diagnosis, but the Right to a Reviewable Diagnostic Process

This investigation began with the question of what happens when a person, after years of searching, finally gains access to specialised autism assessment.

The preceding study examined exclusion before diagnosis: 1,667 people competed for approximately 25 places. Access to clarification, rights and support was thereby effectively made dependent on chance. The present investigation began at the rare point where this first filter had been overcome.

It showed that access to a procedure does not yet mean that the available reality is adequately captured within that procedure.

The second filter lay within diagnosis itself.

No Entitlement to Confirmation

The author had no entitlement to have his autism hypothesis automatically confirmed.

Neither intense self-identification nor high questionnaire scores, an extraordinary work biography or his own research can by themselves compel a clinical diagnosis. A diagnostic institution must be permitted to reach a different result.

The criticism of this paper is therefore not directed against the possibility of a negative finding.

It is directed against the conditions under which such a finding claims scientific and institutional validity.

The central question is not:

> *Should Humboldt have diagnosed the author?*

It is:

> *Could Humboldt show in a traceable way that it had sufficiently captured the available evidence, symmetrically examined competing explanatory models and adequately translated the limitations of its procedure into the reach of its judgement?*

The present documentation raises substantial doubts about this.

The Path from the Person to the Finding

The diagnostic result did not arise through direct access to an objectively given truth.

Between lived life and the later finding lay numerous translations:

> *Life → memory → self-report → follow-up question → observation → note → interpretation → case conference → report.*

Each of these steps could preserve, shorten, reinterpret or lose relevant information.

The author contributed long-term biographical and work-related evidence developed over decades. He is himself active in autism research.

The clinic encountered him with a time-limited clinical procedure, standardised instruments, brief observational situations and a subsequent overall assessment whose internal weighting was not reviewable by the person affected.

The decisive problem was not that clinical observation is fundamentally unsuitable.

It was that the institutionally produced snapshot was given priority over a more extensive long-term reality without this priority being sufficiently justified.

The Disappearance of Evidence

A substantial part of the submitted evidence did not disappear completely from the procedure.

It lost its original meaning.

The almost thirty-year attachment to a single body of work was not recognisably integrated as a possible special interest or monotropic organisation of life.

High AQ and SRS scores remained documented, but were relativised through alternative diagnoses.

The possibility of masking and limited ADOS sensitivity was acknowledged within the finding itself without this resulting in a corresponding limitation of the exclusionary judgement.

The author's unusually high degree of self-knowledge was not necessarily treated as an epistemic resource. It could pass into a model of conviction, self-aggrandisement or narcissistic accentuation.

The data were therefore not simply ignored.

They changed explanatory systems.

Possible neurodivergent evidence became material for a personality-related alternative interpretation.

The Asymmetry of the Burden of Proof

Particularly striking was the unequal burden of proof.

A high threshold appeared to apply to the autism hypothesis. Observable social reciprocity, a low ADOS score and childhood characteristics that could not be reconstructed unequivocally could be weighted strongly against it.

For the narcissistic personality accentuation, by contrast, it remained unclear which comparably dense, long-term and cross-contextual evidence supported it.

Precisely because personality-related attributions can alter a person's credibility and moral perception, they should have been justified at least as strictly as the rejected autism diagnosis.

A diagnostic alternative is not superior merely because it was institutionally formulated.

It must explain more than the model it replaces.

It must connect the life history, not merely distribute individual remainders across different categories.

The Self-Sealing Danger

The personality-related interpretation simultaneously created the danger of a self-sealing structure.

If the author objected, this could appear as lack of insight. If he referred to the significance of his body of work, this could be read as grandiosity. If he demanded a reviewable justification, this could count as entitlement. If he reacted emotionally to the institutional devaluation of his self-explanation, the reaction could in turn confirm the alternative model.

The diagnosis thereby threatened to become protected against correction.

A scientifically open procedure, however, must fundamentally allow for the possibility that the patient's objection is not a symptom but an indication of an error.

A diagnosis must not become true because the person affected defends themselves against it.

Institution and Clinical Judgement

In the case examined, there was also an extraordinary institutional history.

The clinic diagnosed a person who had previously sued it, publicly criticised it and made it the subject of an internationally circulated study. The clinic leadership was informed about the conflict and co-signed the later finding.

This proves neither conscious retaliation nor a deliberately false diagnosis.

It did, however, create a substantial risk of bias and loss of credibility.

Precisely for this reason, a transparent separation between institutional conflict and clinical decision would have been necessary. External referral, independent assessment or at least an open account of the internal state of knowledge could have safeguarded the procedure.

Instead, the assessment formally began as though it were an ordinary, unburdened procedure. The history did not disappear merely because it was initially not discussed.

It remained in the room as an invisible condition.

Theoretical Selectivity

The diagnosis was also not independent of the theoretical model through which autism was read.

A Specialist Outpatient Clinic for Social Interaction necessarily directs substantial attention towards social communication, reciprocity and observable interaction behaviour. This perspective is professionally legitimate and scientifically productive.

But it has limits.

A more social-deficit-oriented model can weigh situationally successful communication against autism. Double Empathy approaches, monotropism, masking research and experience-oriented models can interpret the same situation differently: as learned social performance whose costs and context dependence are barely visible in a brief assessment.

The case therefore called into question not only a diagnostic hypothesis.

It may also have called into question the reach of a particular research model.

Precisely for the work of Prof. Dr Isabel Dziobek and the specialist clinic, this is a relevant scientific question. If people with profiles like that of the author were more frequently included in the autism population, the image of autism might shift: away from a primary deficit in visible social interaction and more towards questions of attachment structure, organisation of attention, compensation, fit and long-term functioning.

The case does not prove conscious theoretical selection.

It does, however, demonstrate the risk that a clinic preferentially recognises as autistic those cases that are already readily readable within its own model and subsequently studies, within this selected population, precisely those characteristics by which the selection was made.

The institution then does not merely describe its research object.

It participates in producing it.

Resource Scarcity and Ontological Overreach

The diagnostic decision was also part of a severely resource-limited system.

Short time windows, standardised procedures, limited reading capacity and the absence of genuinely available second assessment are not merely organisational circumstances. They determine which evidence can be institutionally processed at all.

This becomes problematic when the limit of the procedure is presented as a limit of the person.

A clinic may state:

> *Under the given conditions, the criteria could not be sufficiently confirmed.*

It may not simply infer from this:

> *Autism is not present.*

Recognisability and existence are not identical. Where the procedure can capture certain profiles only to a limited extent, this limitation must remain part of the finding.

Otherwise, resource scarcity becomes ontologised:

> *What does not become sufficiently visible within the available procedure is treated as absent in the person.*

The Consequences of Exclusion

A negative diagnosis does not create a neutral state. The experience remains.

The social and occupational overload remains. The attachment to specific structures of work and time remains. The exhaustion remains. What disappears is institutional recognition of a connection.

In the present case, autism was not merely not confirmed. The autistic self-explanation was overwritten by other categories. This produced diagnostic identity erasure: the person remained with their experiences but was removed from the category through which those experiences had for the first time become coherently understandable to them.

Such exclusion can have consequences for treatment, social law, self-understanding and later assessments.

It can perpetuate itself in files. Future complaints can be read in the light of a documented personality accentuation. The file begins to anticipate the person.

Responsibility for Diagnostic Harm

An institution must be permitted to communicate a negative result even if this severely burdens the person affected.

It must not, however, completely externalise the consequences of its judgement.

The more vulnerable the person, the scarcer alternative diagnostic options and the more consequential the finding, the stronger the requirements regarding:

- transparency;
- communication of uncertainty;
- follow-up care;
- independent review;
- and support according to the actual functional profile.

In the case examined, the author was discharged with a far-reaching description of his person without an equivalent explanation of his life structure or an immediately accessible alternative pathway of care being recognisable.

The institution closed the diagnostic process. The unresolved reality remained with the person.

The Production of the Population

The case therefore extends beyond the individual.

Anyone diagnosed negatively is later absent from the autism population.

This person does not appear in clinical statistics, may not appear in autism-specific research and does not appear as an autistic voice within scientific debate.

If a particular profile is regularly recognised less well, it is absent from the data through which autism is described in the future.

A recursive filter can thereby stabilise itself:

> *Diagnosis preferentially recognises those profiles to which it is already adapted. These profiles form the research group. Research subsequently confirms those characteristics by which the group was selected.*

The blind spot reproduces itself.

A serious assessment of diagnostic quality would therefore also have to investigate those rejected: their later diagnoses, their health development, independent second findings and whether the alternative model offered was actually able to explain their lived reality.

The Connection Between the Two Studies

Together, the two investigations describe a two-stage architecture of selection.

The first study showed:

> *Before diagnosis, resource scarcity determines who is examined at all.*

The second study shows:

> *Within diagnosis, methodological, theoretical and institutional filters determine whose reality can be recognised as autism.*

The first filter produces non-access.

The second produces non-autism.

In both cases, those affected remain with the same problems while the institution can end its responsibility.

The political question therefore shifts.

It is not sufficient to create more assessment places if the procedures themselves cannot adequately incorporate complex profiles.

Nor is it sufficient to improve the methods while access to them remains effectively unattainable.

Both justice in healthcare provision and epistemic justice are required.

No Right to Diagnosis, but a Right to Procedure

Through this study, the author cannot prove that autism is undoubtedly present.

Nor, given the documented limitations, can Humboldt's negative finding be treated as a final scientific refutation of the autism hypothesis.

Between these positions lies the actual subject of the paper.

The author had no right to a particular diagnosis.

He did, however, have a right:

- for his evidence to be recognisably examined;
- for unexamined materials to be identified as such;
- for contradictory data not to disappear into a black box;
- for alternative diagnoses to be justified at least as strictly;
- for institutional conflicts to be treated transparently;
- for objection not to become a symptom;
- for methodological limitations to limit the reach of the judgement;
- and for the possible consequences of an erroneous judgement not to remain entirely with him.

This right is not a special right of a difficult patient. It is the minimum condition of scientifically responsible diagnosis.

The Final Thesis

The central thesis of this investigation is:

> *Diagnostic authority is legitimate only insofar as its epistemic path is traceable, its interpretation corrigible and its claim limited to the actual reach of the procedure.*

Where these conditions are absent, professional assessment becomes an institutional monopoly over reality.

The institution then decides not only which diagnosis is assigned.

It decides which biographical data count, which explanatory models are legitimate, which identity remains valid before authorities and who becomes visible within the scientific population at all.

Precisely for this reason, diagnosis must not be understood as a mere clinical administrative act. It is a powerful form of social production of reality.

Its task is not to deny this power. Its task is to limit it methodologically.

The final demand is therefore not:

> *Always believe the patient.*

It is:

Do not treat their knowledge as raw material while the institutional interpretation invisibly becomes truth.

Nor is it:

When in doubt, assign a diagnosis.

But rather:

When in doubt, formulate the doubt.

Because a scientifically honest diagnostic process does not have to know everything. It has to know where its knowledge ends.

Final Word: The As Yet Unresolved Legal Dimension

At the end, a question therefore remains that goes beyond scientific methodological criticism: **How many actually autistic people may not have been recognised by the Humboldt clinic in recent years because their profiles did not fit sufficiently within its socially interaction-focused, time-limited and resource-dependent procedure?**

This question can and should be asked of every autism diagnostic centre worldwide.

That number is currently unknown. Precisely this is part of the problem. If even a relevant proportion of those rejected each year were assessed false-negative, the consequences could extend to hundreds or, over longer periods, thousands of people: lost opportunities for treatment and participation, incorrect alternative diagnoses, continued health-damaging adaptation, lack of rights under social law and self-confirming documentary trajectories.

This also raises the legal question of whether a diagnostic system that does not adequately disclose known methodological limitations, does not make its decisions reviewable, and neither systematically follows up nor corrects possible misclassifications fulfils its obligations under the treatment relationship, documentation requirements and, where applicable, public law.

Patients' rights law requires professionally appropriate treatment, information about suitability, risks and prospects of success, as well as traceable documentation; in cases of culpable injury to health or breach of official duty, questions of liability may in principle also arise.

At the same time, the systematic exclusion of disabled people touches upon the right to non-discriminatory access to healthcare and participation. The present individual case can prove neither the number of possible erroneous decisions nor any specific legal liability.

It does, however, compel an investigation that apparently remains absent: **What is the false-negative rate of this clinic, who bears the consequences, and at what point does diagnostic uncertainty become institutionally caused harm?**

If it were shown that people with particular autistic profiles had been systematically excluded, this would no longer be merely a professional error in individual diagnoses. It would be a healthcare scandal with potentially far-reaching human-rights and legal responsibility.

The less capable a diagnostic system is, because of its theoretical and methodological limitations, of reliably recognising autism, the less its negative result may legally be used as proof of the absence of autism.

If a legally relevant neurodivergent impairment cannot be conclusively classified despite substantial and consistent indications because diagnostic procedures are limited or inaccessible, the resulting uncertainty must not fall exclusively to the detriment of the person affected.

The more strongly the state makes rights dependent on a particular diagnosis, the greater its duty to provide an accessible, valid and error-sensitive procedure for determining that diagnosis.

This gives rise to the following question: The state may decide on legal consequences. It does not necessarily follow, however, that it may claim sovereign authority to decide what a human being ontologically or in terms of identity 'is'.

Anyone who institutionally determines which epistemic procedures decide rights must also assume responsibility for the limitations and systematic errors of those procedures.

The state cannot merely claim epistemic authority. It must also assume **epistemic liability.**

Appendix 1: Scientific Statement on the Need for Explanation When Rejecting an Autism Spectrum Hypothesis

Scientific Framing of the Observed Phenomenon Constellation
Introduction
In the following, central structural characteristics of my life and working style, documented over several decades, are systematically assigned to relevant scientific conceptual fields.
The aim is not to anticipate a diagnosis but to situate the question of **within which known spectrum such constellations of characteristics typically occur with higher frequency**, and what explanatory power competing models possess. The purpose is therefore to demonstrate the **extreme probability relations** involved. Since probability itself constitutes the operative standard of evaluation in social law, this question carries significant evidentiary weight.
The particularity of the present case lies less in individual traits than in their:

- extraordinary duration
- intensity
- cross-domain recurrence
- functional cost
- and mutual confirmation within a large and coherent body of work

This body of work is internationally documented within autism research contexts and is fully publicly accessible:
https://zenodo.org/communities/operatoric-research-corpus-archive
https://orcid.org/0009-0002-0143-5949
I therefore list below the key criteria which, from the perspective of current research, speak in favor of an autism spectrum interpretation.

1. Veridical Mapping and Systematic Isomorphism Formation
Description of the Phenomenon
Over a period of approximately three decades, an extensive network of structural correspondences between **physical, societal, epistemological, and aesthetic domains** has been developed. These works frequently reference each other, form recursive structures, and aim at formal coherence across media and long time periods.
In this case we are therefore dealing with a capacity to detect patterns on a scale that contributes not only to debates in physics but also opens modelling perspectives in economics and social science.
Veridical Mapping refers to a phenomenon in which predominantly autistic individuals can recognize and transfer patterns with little or almost no subjective distortion. Structural patterns are perceived in a comparatively "naked" form and can therefore be observed across contexts with relatively little subjective filtering.
A well-known example is an autistic individual who can redraw an entire city from memory as if it were a photograph — essentially a 1:1 mapping.

Scientific Terminology
This phenomenon is discussed in research under several related terms:

- veridical mapping
- structural analogy competence
- systemizing cognition

- hyperlexia / savant-like pattern transfer
- synesthetic or cross-modal representational coupling

Distribution in the Field
Such abilities are **not exclusive to autism**, but among non-autistic individuals they are rare. In addition, in non-autistic populations such phenomena are often temporary rather than sustained over decades.

Relevance of the Present Constellation
In this case the ability can be recognized both by AI analysis and by human experts through the **fractal architecture of the work corpus**.
The corpus therefore represents a potentially valuable research case, because **longitudinal documentation of such pattern-recognition phenomena over a 30-year period is extremely rare.**

2. Monotropic Attentional Binding

Description of the Phenomenon
Across more than three decades an **extraordinarily stable and almost exclusive focus on a coherent thematic complex** can be demonstrated.
This focus is not project-based or episodic but structures:

- biography
- daily organization
- allocation of energy
- social relationships
- professional decisions

The existing works — books, research papers, films, essays — despite their different formats, remain functionally oriented toward a **central operatoric core**.
New works modify, extend, or reorganize this core but do not abandon it. Earlier formulations are repeatedly revisited, corrected, refined, and integrated.
Thus what appears is **not a sequence of changing interests but a stable attention field.**

Visibility Within the Work
Monotropism becomes visible for example through:

- continuous development of the same structural framework across decades
- integration of artistic forms into the same research problem
- subordination of narrative or aesthetic aspects to systemic coherence
- prioritization of internal logical necessity over external recognition or market demands
- consistent re-integration of new themes into the same operatoric framework

Even under extreme external stress or complete absence of recognition, this focus remains stable.

Reaction to Interruption or External Control
Repeatedly documented are:

- significant conflicts in institutional or collaborative environments
- termination of employment due to perceived structural inconsistencies
- severe psychophysiological stress when working outside the dominant focus
- inability to organize work permanently according to externally imposed structures

This does not reflect lack of will but the **structural dominance of the bound attention field**.

Scientific Classification
Within autism research such patterns are described under the concept of **monotropism**, which proposes that attention is **not evenly distributed but strongly channeled**.
This produces:

- extraordinary performance within the focus
- difficulties in rapidly shifting social or professional environments

Distribution in the Population
Monotropic interests occur outside autism as well.
However, **when they dominate the organization of an entire life across decades**, particularly combined with substantial participation conflicts, they appear far more frequently in autism spectrum populations.
Typically such focus is **not pursued against social norms to the point of personal self-destruction**. In this case, however, it clearly is.

Significance of the Intensity in the Present Case
The specificity lies in the scale:

- duration over several decades
- thousands of pages of continuous production
- repeated prioritization of internal coherence even under massive personal disadvantage
- resistance to redirection by external incentives or sanctions

This combination significantly increases the probability that the phenomenon reflects a **fundamental cognitive organization rather than strong interest or specialization**.
Such a constellation cannot plausibly be explained by personality disorders or obsessive-compulsive disorder, since the work itself remains logically coherent, scientifically connected, and externally interpretable.

3. Energy Acquisition Through Structure
Description of the Phenomenon
Across the documented life course a recurring pattern appears in which **motivation, activation, and endurance arise primarily where structural relations can be recognized, condensed, or developed further.**
Cognitive work does not merely function as intellectual activity but as a **direct source of psychological and physiological regulation**.
In contrast, activities perceived as **arbitrary, contradictory, or structurally incoherent** regularly lead to exhaustion, internal resistance, or conflict.

Visibility in the Work and Biography
This link between energy and structure becomes visible through:

- sustained productivity under extremely precarious living conditions
- descriptions of a "pull" or necessity to resolve structural relations
- repeated return to identical questions even after severe setbacks
- independence from recognition or economic incentives

Simultaneously documented are:

- collapse or withdrawal from work contexts where coherence cannot be established
- somatic stress reactions when confronted with irrational requirements
- inability to sustain motivation solely through external rewards

Thus a **primary coupling between motivation and internal coherence** appears.

Distinction From Other Motivation Models
This pattern differs significantly from:

- career-driven motivation
- desire for social recognition
- situational ambition

The activity persists even where these factors are entirely absent or negative.

Scientific Context
In autism research similar dynamics are discussed in relation to:

- special interests
- intrinsic information-based motivation
- flow-like states within narrow attention channels
- self-regulatory functions of intense cognitive engagement

In such cases structural processing plays both a **stabilizing and energizing role**.

Distribution
Although intrinsically motivated individuals exist outside autism, it is far rarer that:

- motivation arises almost exclusively from structural coherence
- external incentives remain largely ineffective
- lack of coherence causes major functional collapse

This intensity is frequently reported in autistic self-descriptions and case studies.
In such contexts these dynamics are not arbitrary symptoms but **functional necessities for maintaining the regulatory affordances of the altered nervous system**.

Significance in the Present Case
Again the distinguishing factor is scale:

- decades of sustained productivity without reinforcement
- repeated acceptance of severe personal disadvantage
- absence of substitutable motivational sources

Structure therefore appears not merely as a preference but as a **primary condition for agency itself.**

4. Ability–Function Discrepancy
Description of the Phenomenon
Across the entire documented period a striking and recurring **gap exists between high cognitive, analytical, and creative capacity on the one hand and the ability to translate these capacities into stable employment trajectories or cooperative institutional integration on the other.**
The difficulty lies not in lack of competence but in the **translation of competence into institutional contexts.**

Visibility in Work and Life History
The discrepancy appears through:

- extensive theoretical and publishing production over decades
- development of complex models connected to existing academic debates
- demonstrated capacity for long-term autonomous work

Contrasted with:

- repeated failure or termination of employment
- conflicts within team and hierarchical environments
- lack of stable institutional affiliation
- severe economic precarity despite high productivity

Thus the issue is **not a performance deficit but a mismatch between ability and institutional fit.**

Character of the Impairment

Problems typically arise where systems require:

- flexible priority shifting
- acceptance of pragmatic contradictions
- submission to externally imposed procedures
- navigation of informal social expectations

These are precisely the areas where breakdowns repeatedly occur.

Scientific Interpretation

Recent autism research increasingly documents this constellation, particularly among **high-intelligence or verbally compensated autistic adults**.

Common findings include:

- strong performance in self-structured contexts
- simultaneous difficulty integrating into organizations
- high vulnerability to overload caused by social ambiguity

This discrepancy suggests that **surface competence assessments frequently underestimate the underlying functional limitations.**

If you want, Timothy, I can also help you with two things that would significantly strengthen this appendix scientifically:

1. **Add precise literature references** (Mottron, Murray, Lawson, Monotropism theory, etc.).
2. **Add a short statistical reasoning paragraph** explaining why rejecting an autism hypothesis would require an alternative model with comparable explanatory power.

Both would make the appendix **much harder for courts or experts to dismiss**.

4. Ability–Function Discrepancy (continued)

Distribution in the Field

People outside the autism spectrum can also experience difficulties in employment or remain below their potential.

Less common, however, is a combination of:

- exceptionally high productivity demonstrated over many years
- simultaneous chronic instability
- recurring and structurally similar conflict patterns
- and the absence of improvement despite repeated learning and adaptation attempts

This specific form of stable non-fit is reported comparatively often in autism-spectrum biographies.

Significance of the Pattern in the Present Case

In the present trajectory the discrepancy is not episodic but persistent across decades. Neither motivation nor cognitive capacity appears sufficient to overcome the integration problems.

This observation argues against explanations primarily based on lack of effort, insufficient qualification, or situational misfortune, and instead directs attention toward fundamental differences in cognitive and social organization.

5. Masking and Situational Competence (Camouflaging)

Description of the Phenomenon

It has repeatedly been reported and documented that in direct, time-limited, or formally structured interactions an impression of social competence, verbal fluency, and adaptability can emerge.
This situational competence, however, contrasts sharply with the long-term trajectories in which breakdown, overload, or social disintegration regularly follow.
The phenomenon therefore concerns not momentary interactional ability but the sustainability of adaptation.

Visibility in the Life Course

The discrepancy becomes visible through patterns such as:

- repeated positive or at least unproblematic first encounters
- the ability to conduct intellectually differentiated conversations
- temporary fulfilment of formal expectations

Followed frequently by:

- rapid exhaustion
- increasing misunderstandings
- overload caused by implicit expectations
- withdrawal or conflict

Thus the short-term performance proves structurally unstable over time.

Mechanism of Misinterpretation

Short observations tend to overweight visible competence and underweight later breakdowns.
As a result, observers may conclude that the person is fundamentally capable of integration, even though the long-term data suggest the opposite.

Scientific Classification

This pattern is widely discussed in current literature under the concepts of camouflaging or masking.
These terms describe the ability to temporarily meet social expectations through learned or deliberate strategies, often in order to avoid rejection or comply with external norms.
Research simultaneously shows that these adaptation strategies can involve high internal costs and do not necessarily lead to sustainable participation.

Distribution in the Field

Non-autistic individuals can also adapt their behavior in specific contexts.
What is more characteristic of autistic biographies, however, is:

- the strong discrepancy between short-term impression and long-term trajectory
- the repeated experience of failure despite effort
- the mismatch between external perceptions of competence and internal strain

Significance of the Pattern in the Present Case

In the present life course this dynamic recurs over many years.
Situations that initially appear cooperative or constructive later develop into structural conflict.
The decisive indicator therefore lies not in the capacity for momentary interaction but in the absence of long-term stabilization.
For this reason, drawing conclusions about functional capacity from isolated observation appointments becomes methodologically problematic.

6. Rule Orientation and Justice Sensitivity

Description of the Phenomenon

Across the entire life course a pronounced orientation toward formal consistency, internal coherence, and explicable reasoning can be observed.

Rules are not primarily understood as social conventions but as expressions of structural truth.

Pragmatic adjustments that appear socially common but logically inconsistent can therefore be difficult or impossible to accept.

Visibility in Behavior and Work

This structural orientation appears through:

- repeated conflicts with institutions when procedures are perceived as contradictory
- sustained insistence on formal clarification even at personal cost
- limited willingness to overlook inconsistencies for the sake of expedient solutions
- strong reactions to perceived injustice or double standards

The body of work simultaneously reflects an enduring orientation toward internal coherence, with argumentative lines pursued across years even when strategically disadvantageous.

Character of the Motivation

Crucially, this orientation is not primarily moralistic or performative.

Instead it is experienced as a necessary condition for maintaining a coherent reality.

Inconsistency is not simply disagreement but a structural destabilization.

Scientific Classification

Autism research frequently reports heightened orientation toward:

- rules
- fairness
- logical clarity
- equal treatment

Correspondingly, difficulties often arise when navigating:

- social grey zones
- implicit hierarchies
- pragmatic exceptions

These dynamics are widely discussed as contributors to everyday and workplace conflict**.**

Distribution in the Field

Neurotypical individuals can also display strong principle-based or justice-oriented behavior.

Less common, however, is the degree of prioritization in which:

- strategic disadvantages are consistently accepted
- social relationships suffer as a consequence
- flexible adaptation to situational expectations remains limited

This constellation is frequently reported in autistic profiles.

Significance of the Pattern in the Present Case

The documented life history shows that rule orientation persists even under extreme pressure.

Neither economic hardship nor institutional disadvantage results in a fundamental relativization of this orientation.

The pattern therefore appears less as an attitude and more as a deeply embedded organizational principle of perception and decision-making.

7. Social Exclusion Despite Intent to Cooperate

Description of the Phenomenon

Across numerous contexts — family, partnerships, professional environments, institutional interactions — a recurring pattern appears in which exclusion, withdrawal of others, or escalation occurs despite a clear willingness to cooperate.

The difficulty therefore lies not in lack of motivation for contact but in the stability of relationships over time.

Visibility in the Life Course

Typical trajectories include:

- initially successful or neutral interactions
- genuine attempts at clarity and cooperation
- growing irritation among interaction partners
- attribution of difficulty, nonconformity, or excessive intensity
- eventual withdrawal, breakdown, or exclusion

Notably, this pattern appears independent of the specific social environment.

Nature of the Misunderstanding

Often the difficulty concerns not the content of communication but its form, for example:

- directness
- degree of systematization
- insistence on precision
- absence of implicit social signalling

Thus a gap emerges between intended cooperation and perceived effect.

Scientific Classification

Research frequently describes this pattern under the concept of altered social reciprocity.

The central point is that difficulties arise not from lack of interest in others but from differences in communication and expectation frameworks.

Many autistic individuals report repeatedly being misunderstood or unintentionally causing irritation despite good intentions.

Distribution in the Field

Misunderstandings occur in all groups.

What is unusual here is the high reproducibility across decades and situations, even when conscious efforts to adapt are made.

This persistence of non-fit is significantly more common in autistic life histories.

Significance of the Pattern in the Present Case

In the present trajectory exclusion appears not as an isolated event but as a recurring structural endpoint.

Positive intentions do not lead to gradual integration but repeatedly end in similar breakdowns.

This pattern argues against explanations based primarily on unwillingness, provocation, or social indifference, and instead suggests structural differences in perception and interaction.

8. Self-Regulation, Stimming, and Sensory Particularities

Description of the Phenomenon

Physical or motor strategies are repeatedly reported that serve to stabilize attention, arousal level, or inner tension. These may include movement patterns, rhythmic actions, or other forms of self-soothing.

In addition, increased sensitivities exist toward certain environmental stimuli such as sounds, smells, or tactile impressions.

Function in Everyday Life

These behaviors occur especially:

- under overload
- during phases of intensive cognitive activity
- under uncertainty or heightened stimulus density

They have a regulating effect and often make it possible for work or interaction to continue at all.

Visibility in the Life Course

It is documented that such forms of self-regulation occur not sporadically but regularly and are experienced by the person themselves as necessary. They are described not as habits, but as functional prerequisites for the capacity to act.

Scientific Classification

Self-stimulatory or self-regulatory behaviors—often referred to as **stimming**—are a well-described phenomenon within the autism spectrum. They are understood as mechanisms by which sensory or emotional states are modulated.

Sensory hyper- or hyposensitivities likewise belong to the frequently documented features.

Distribution in the Field

Similar behaviors can also occur in non-autistic people, for example under stress.

Typical of spectrum-related profiles, however, are:

- their regularity
- their functional significance for stability
- and their close coupling to cognitive demands

Significance of the Pattern in the Present Case

The repeated need for such regulatory techniques, especially in connection with intensive intellectual work and social strain, speaks for a deeper sensory and neurocognitive involvement.

This extends the analysis beyond purely personality- or motivation-based models.

9. Mode of Production and Style as a Cognitive Organizational Signature

Description of the Phenomenon

In the texts and filmic works presented here, a recurring prioritization of **inner systemic coherence** over conventional expectations of dramaturgy, reader guidance, or didactic simplification becomes visible. Arguments are often repeated, varied, and recursively referred back to earlier passages. New aspects appear not as independent topics, but as modulations of an underlying structural core.

Artistic means are not primarily used for emotionalization or entertainment, but serve the clarification or embodiment of theoretical relations.

Visibility in the Work

This pattern is recognizable, among other things, through:

- frequent references back to previously introduced models

- recurrence of identical motifs in different contexts
- high tolerance for reader burden in favor of formal precision
- little willingness to shorten arguments for the sake of rhetorical smoothness
- blending of essay, theory, protocol, and narration into a functional unity

Writing thus follows more the logic of a growing system than the expectations of external recipients.

Communicative Consequence

For many readers this structure can be difficult to access, because it is not organized according to linear strategies of communication. At the same time, a high internal coherence arises for the writing person, because each part remains connected to the whole.

Scientific Classification

In the literature on autism and neurodivergence, differences in communicative organization are repeatedly described. These include:

- preference for precision over social adaptation
- increased repetition in order to secure structural stability
- lesser weighting of implicit audience expectations
- strong thematic coherence over long periods of time

Such features are understood not as deficits, but as expressions of differently organized information processing.

Distribution in the Field

Non-neurotypical writing and thinking styles are by no means exclusively autistic.
What is unusual, however, is a dominance of this organizational form, sustained over decades and determining production, especially when it remains associated with substantial social or institutional disadvantages.

Significance of the Pattern in the Present Case

The constancy of the described style across many works argues against situational or fashionable influences. Instead, it points to a stable, deeply anchored cognitive architecture in which **system preservation takes precedence over ease of reception**.

9a. Addition to Mode of Production and Style: Embodied Thinking and Affect-Bound Rationality

Description of the Phenomenon

In the working mode described, rational thinking cannot be separated from emotional or existential involvement. Knowledge does not arise from distanced observation, but from immediate co-enactment. Abstraction without inner resonance does not lead to clarity, but to blockage or loss of meaning.
Emotional intensity therefore functions not as a disturbance, but as a **precondition of precision**.

Visibility in the Work

This pattern becomes clear through:

- the connection of theoretical argumentation with autobiographical experience
- the repeated insistence that truth must be embodied
- the rejection of purely formal or strategic positionings
- the high willingness to bear personal consequences for the sake of conceptual accuracy

The text arises from participation, not from observation.

Function for Knowledge
Affective involvement here serves as a form of reality-testing.
Whatever produces no inner bond is considered insufficiently integrated. This prevents concepts from remaining merely formally correct while existentially empty.

Scientific Classification
In more recent discussions of autism and neurodivergence, it is increasingly emphasized that the supposed "lack of emotion" is a false image. Instead, intense but differently organized forms of feeling and attachment are frequently described.
It is likewise emphasized that thinking and feeling may be not separate but closely intertwined. In some models, precisely this coupling is understood as the basis of a special form of accuracy.

Distribution in the Field
Embodied or engaged modes of thinking also exist outside autism.
What is unusual, however, is a situation in which distancing diminishes functional capacity while involvement increases it, and in which this structure remains stable across decades.

Significance of the Pattern in the Present Case
The documented inability to adopt purely strategic or outwardly neutral positions, even where these would bring advantages, indicates that affective attachment is **not a choice but a condition of functioning**.
In this respect, the present case contradicts the widespread assumption that rationality must necessarily be linked to emotional distance.

10. Persistence of Activity Despite Lack of External Reinforcement
Description of the Phenomenon
Over more than three decades, the described research and production activity has been continuously maintained, although institutional recognition, economic stabilization, or social confirmation were largely absent or even contradicted by negative experiences.
The activity therefore proved independent of classical reinforcement mechanisms such as career prospects, reputation, or material security.

Visibility in the Life Course
Observable in particular are:

- continuous work despite repeated rejection
- maintenance of complex projects under precarious living conditions
- no reduction of engagement even where recognition was minimally likely
- resumption of work even after severe phases of burden

The behavior thus contradicts the expectation that motivation is essentially governed by external feedback.

Motivational Particularity
The drive appears to arise primarily from an inner necessity to clarify, stabilize, or continue structural relations. Activity is experienced not as a means toward an external purpose, but as an immediate condition of inner order.

Scientific Classification
Autism research frequently describes that special interests and systemic questions can possess a **self-sustaining quality**. They serve functions of orientation, regulation, and identity stability and therefore persist even where external reinforcers are absent.

Distribution in the Field
Highly intrinsically motivated individuals also exist in other groups.
What is unusual, however, is such long-term persistence alongside:

- lack of institutional integration
- continuing material insecurity
- and repeated negative feedback

Precisely this resistance to external steering attempts is reported comparatively often in autistic life descriptions.

Significance of the Pattern in the Present Case
The activity maintained over decades under adverse conditions reduces the explanatory power of models that rely primarily on the search for recognition, social positioning, or opportunistic interests. Instead, the assumption gains weight that a deeply anchored, structure-bound form of motivation is present.

Summary Professional Consideration
Taken in isolation, each feature may also occur outside autism.
The present situation, however, is characterized by **exceptional simultaneity, duration, intensity, and mutual reinforcement**.
It is precisely this convergence that leads autism-spectrum models to provide high integrative explanatory power, whereas competing explanations often require a greater number of additional assumptions.

Demonstration of the Special Need for Explanation When Rejecting the Autism Hypothesis
1. Starting Point
In the present case there exists an exceptionally extensive life, work, and conflict history documented over decades.
This includes, among other things:

- a disturbance of occupational and social integration persisting for more than two decades
- recurring communication and interaction breakdowns of structurally similar form
- a pronounced and long-term stable monotropic working style
- extensive written and medial self-productions with high internal coherence
- documented sensory particularities and forms of self-regulation
- a considerable discrepancy between cognitive capacity and real participation stability

Even within the existing professional material, numerous features are described that in principle belong to the autistic spectrum.
There is therefore an undeniable and considerable **need for explanation**.

2. Integrative Power of the Autism Hypothesis
The assumption of an autism-spectrum constellation makes it possible to explain, with a relatively unified functional model, at the same time:

- the long-term persistence of the conspicuous features
- the particular form of attentional binding

- the specific social frictions
- the energy and overload dynamics
- the repeated institutional conflict patterns
- the discrepancy between ability and implementability

Regardless of whether this hypothesis is ultimately confirmed, it possesses a high explanatory reach.

3. Consequences of Rejection

If this hypothesis is rejected, the need for explanation does not thereby disappear.
Rather, there arises the necessity of showing:

- **which alternative model**
- **with which concrete mechanisms**

is supposed to explain the documented long-term phenomena at least as coherently, with as little contradiction, and with equal predictive capacity.
A merely theoretical possibility is insufficient for this, because it creates neither orientation nor functional capacity.

4. Depth of Justification as a Function of the Data Situation

As the density, duration, and convergence of the available information increase, the burden of justification for a rejecting decision necessarily increases as well.
The closer the body of evidence comes to operating near diagnostic criteria, the more precisely it must be stated:

- which elements are considered not fulfilled
- why they are not weighted as sufficient despite the existing indications
- and in what respect alternative assumptions are supposed to be superior
-

5. Practical Implication

Without a correspondingly powerful counter-model, the situation remains in a state of lack of explanation.
This impedes not only individual orientation, but any factually appropriate planning of support, reasonableness, and future stabilization.

6. Result

The present constellation therefore does **not** lead automatically to a confirmation of the autism hypothesis. It does, however, lead to the conclusion that **its rejection is subject to a particularly high duty of presentation and justification**.
The high probability of an autism confirmation is far more comprehensible than its alternative. It must also be taken into account that the consequences of rejection—together with denied accommodations and denied support—face a high threshold here if no alternative explanation is provided and similarly comprehensively justified.

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Declaration of AI usage

Generative AI tools, including ChatGPT, were used during manuscript preparation to support language editing, structural refinement, and the critical review and clarification of formulations and arguments. The research, empirical material, theoretical concepts, interpretations, and scholarly conclusions are those of the author. All AI-assisted material was critically reviewed, revised where necessary, and verified by the author, who assumes full responsibility for the final manuscript.

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